ONE COMMUNITY HEALTH

541-386-3680
www.onecommunityhealth.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name ______________________ Date of Birth ______________
Address ______________________
City ______________ State ______ Zip ______ Phone ______________

Disclose Records From:
Check one:
☑ One Community Health
☐ Other (Specify)

Name One Community Health Phone (541)386-6380
Address 849 Pacific Avenue Fax (541)256- 4208
City Hood River State OR Zip 97031

Disclose Records To:
Check one:
☐ Self
☑ Other

Name Wy'East Middle School Attendance and Counseling Office
Address 3000 Wyeast Road #8424
City Hood River State OR Zip 97031
Phone Number (541) 354-1548 Fax Number ______________ E-mail ______________

Method/Format:
(How and when do you want the information?)

Check one:
☑ Secure E-mail Link ☐ Mail (☐ Paper or ☐ CD) ☐ Pick-Up ☐ Fax ☐ MyChart

NOTE: Most requests are processed within 30 days ☐ Urgent Request. Records needed by: ______________

Purpose:
☐ Personal Copy
☐ Care Continuity
☐ Transfer of Care
☐ Insurance
☐ Worker's Compensation
☐ Legal/Attorney
☑ Other Patient school based telehealth appointment provider, dates and times

Information to be Disclosed:

Date(s) of Service: From Onset of school-based telehealth services To Discontinuation of school-based telehealth services
(Unless otherwise indicated, records from the past 12 months will be released)

☐ Well Child Checks
☐ History & Physical Exam
☐ Medication List
☐ X-ray/Imaging
☐ Immunization/Allergy Record
☐ Pathology Reports
☐ Laboratory Reports
☐ Visit Notes
☑ Other Records (Specify record types(s)) Patient school based telehealth appointment provider, dates and times

☐ All Clinical Records ☐ Billing Records

Special Authorization Section

The following types of records will not be disclosed unless checked:

☐ HIV Testing and Results
☐ Sexually-Transmitted Disease
☐ Genetic Records
Behavioral/Mental Health Records
☐ Assessment ☐ Treatment Plan ☑ Attendance ☐ Discharge Plan ☐ Other (specify): ______________
Alcohol, Drug, or Substance Use Records
☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (specify): ______________

- You are not required to sign this Authorization. The care provided to you by One Community Health will not be affected if you do not sign.
- You may revoke/cancel this Authorization at any time by writing to One Community Health's Privacy Officer at 849 Pacific Ave. Hood River, OR 97031. Revoking/canceling this Authorization will not affect any use or disclosure of your health information that has already taken place. This authorization will expire on the following date or event: Secodary School Commencement (if none specified, in 12 months), unless you revoke/cancel this Authorization sooner.
- Once your health information is disclosed, it may no longer be protected by federal and state privacy laws and re-disclosed to others. However, certain types of sensitive information (such as HIV/AIDS information, behavioral health information, genetic testing information and substance use information) may be protected by laws that do not allow re-disclosure.
- This Authorization must be signed and dated by the patient or the person authorized by law to serve as the patient's personal representative. A personal representative who is the patient's legal guardian or custodian or has health care power of attorney for the patient must provide legal documentation demonstrating his/her authority.
- OCH may charge a reasonable cost-based fee for copies of records in compliance with state and federal laws.

I have reviewed and understand this Authorization to Disclose Protected Health Information

Signature ______________ Date ______________

Print Name ______________ Relationship to Patient ______________

TO BE COMPLETED BY STAFF:

Initials of person disclosing information Date ______________
Photo ID/Signature verified ______________
Medical Record Number ______________
Patient Encounter Number ______________