



**OHSU School of Nursing
Health Network for Rural Schools**
One University Blvd
La Grande, OR 97850
Voice: (541) 963-3648
Fax: (541) 963-3737

Name: _____

Birth date: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION MUST BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person/entity disclosing information)

to use and/or disclose the specific health information described below regarding:

(Name of the individual)

consisting of: _____ Physician reports _____ X-rays _____ Labs
_____ ED _____ Billing _____ Other, specify _____

to: _____
(School District/name and address of recipient or recipients)

for the purpose of: _____
(Describe each purpose of disclosure)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

- _____ HIV/AIDS information
- _____ Mental health information
- _____ Genetic testing information
- _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect our enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with our permission cannot be undone.

To revoke this authorization, please send a written statement to Program Director, OHSU School of Nursing-Health Network for Rural Schools, One University Blvd, La Grande, OR 97850.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, and treatment or referral information.

I have read this authorization and I understand it.

Unless revoked, this authorization expires _____ (insert applicable date or events).

By: _____ Date: _____
(Signature of individual or personal representative)

Description of Personal representative's authority: _____