COLUMBIA MEMORIAL HOSPITAL

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Astoria, Oregon 97103
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GENERAL OR PSYCHOTHERAPY NOTE AUTHORIZATION

Purpose: This form is used to authorize us to use or disclose protected health information or for another person to disclose protected health information to us for the purpose stated.

To offset the cost associated with copying, equipment, and supplies, there will be a $15.00 charge for records that must be paid prior to delivery.

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ DOB: _____

Medical Record Number: _____ Social Security Number: _____

SECTION B: The use and/or disclosure being authorized.

	Date of service
☒ Operative report	_____
☐ Lab Reports	_____
☐ X-Ray Film/Reports	_____
☐ EKG/EEG	_____
☐ Emergency Room	_____
☐ Discharge Summary	_____
☐ Physical Therapy	_____
☐ History and Physical	_____
☐ Progress Notes	_____
☐ Billing Information	_____
☐ Other*	_____

(**specify*)_____

☐ Sent To: ☐ From

_____
Individual/Facility / Agency

_____
Address

_____
City / State / Zip

_____
Tel Number

_____
Fax Number

I specifically release the following:

☐ HIV/AIDS/STD's _____ *(Initials)* ☐ Drug/Alcohol/Mental Health Dx & Tx _____ *(Initials)* ☐ Genetic Info _____ *(Initials)*

PATIENT'S SIGNATURE.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Patient Signature/Representative:_____Date: _____

Personal Representative's Name: _____
(Please print)

Relationship to Individual: _____

Witness: _____

Purpose of this Authorization:

☐ Insurance ☐ Continuing Care ☐ Legal ☐ Other:_____

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: Expiration and revocation.

Expiration: This authorization will expire one year from date of authorization or:

On _____/_____/_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

Name	*Relationship*	*Tel#*
Name	*Relationship*	*Tel#*
Name	*Relationship*	*Tel#*
Name	*Relationship*	*Tel#*
Patient Care Partner	*Relationship*	*Tel#*

SECTION D: Psychotherapy notes. ☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

FOR HOSPITAL USE

Date Prepared:_____ Initial: _____ ☐ Pt. Pick-Up ☐ Mailed ☐ Faxed Date of release:_____

Include this authorization in the individual's medical records.

Verification of ID: ☐ Photo ID ☐ Person is known to me ☐ Government Credentials *e.g.* Badge

Verified by: *(CMH Staff Signature):*_____

Medical Record Number_____