891 23rd Street, N.E.
Salem, OR 97301
Ph# (503) 364-2181
Fax# (503) 364-0364

Form B: Authorization to Use/Disclose Health Information

I authorize Childhood Health Associates of Salem (CHAOS) to use and disclose a copy of the specific health and medical information described below regarding:

Name of Patient: _____ DOB: _____

Requesting: CHAOS Records____ All Records_____ Immunization Records Only_____
(only) (including records from previous doctors)

Other Records (Specify)_____

To release Specially Protected Information, please initial where appropriate:

_____Mental Health (inc. ADHD/ADD), if patient over 14, they must initial

_____Alcohol/Chemical Dependency, if patient over 14, they must initial

_____Sexually Trasmitted Diseases, patient must initial

_____Birth Control, patient must initial

_____ Genetic Information

_____HIV/AIDS

_____
Signature of person initialling above

To:_____
*(Name and address **Required**)*

If need your records on paper instead of on CD (PDF formatted) , check here. ____

for the purpose of:_____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

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Patient: _____ DOB: _____

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: 1. Creating health information about you to be disclosed to a third party; or 2. For the purpose of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this *Authorization*, please send a written statement to Ingrid Hogenstad at 891 23rd St. NE, Salem, OR 97301 that identifies the date you signed this *Authorization*, the recipient of the information identified in this *Authorization*, and states that you are revoking this *Authorization*.
This Authorization will expire on the earlier of either_____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure of the above-described purpose.

I have reviewed and I understand this *Authorization*. I also understand that the information used or disclosed pursuant to this *Authorization* may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Foster parents: Please initials only!

By:_____

Date:_____

(Patient's foster parent)

Note: If initialed by a foster parent, this authorization is valid only for release of immunization records to school administration. Foster parents do not have parental HIPPA rights for foster children in their care.

By:_____ Date:_____
(Patient)

By:_____ Date:_____
(Patient's legal representative)

Representative's authority (e.g. parent, legal guardian):_____
