AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect my ability to obtain health care services or reimbursement for services unless this authorization is required to bill my insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? ☐Yes ☐No
Patient's Mailing Address		

Healthcare Provider to **Release** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Person or Agency to **Receive** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Purpose of release: Access to MyHealth record

I authorize the disclosure of all information maintained in my MyHealth record, including the following specific information as it may pertain to me (the following items **must be initialed** to authorize access to your MyHealth record):

_____ HIV-positive test results and HIV diagnosis
_____ Mental health information and/or records (Oregon only)
_____ Genetic testing information and/or records (Oregon only)
_____ Other sexually transmitted diseases (Washington only)
_____ Drug/alcohol diagnosis, treatment or referral information. Federal regulations require you to describe how much and what kind of information is to be disclosed:

_____

Federal and/or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information, and drug/alcohol diagnosis, treatment or referral information.

The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing my health information to someone else, and this authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless this authorization is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will remain in effect for so long as I maintain a MyHealth account. However, if I am under the age of 18, this authorization will expire when I turn 18 years old.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (if other than the patient, proof of authority is required.) Relationship to Patient