# Instructions for the release of information *to* COPA

How to fill out COPA's "Authorization to Release and/or Receive Protected Health Information" form

**Please note**: If the patient is **15 years old or older**, they must fill out and sign the release themselves

1. Include **name, address** and **phone number** of the clinic or person releasing records

2. Include **full name, date of birth, phone number** and **address** of the patient to whom the records pertain

3. "X" the box to indicate the purpose of the records request

4. **Initial or "X"** beside what information you would like COPA to received. Please also fill in the time period of the records being released.

5. **Initial** beside each category you would like COPA to received. Only the information that you initial beside will be received. This information will not be received if you place an "X" on the line- you must initial.

6. Sign and print your name, date and "X" the appropriate relationship field box

COPA
CENTRAL OREGON
PEDIATRIC ASSOCIATES

**www.copakids.com**
**2200 NE Professional Ct.**
**Bend, Oregon 97701**
**Phone: 541-389-6313**
**Fax: 541-389-8760**

# AUTHORIZATION TO RELEASE AND/OR RECEIVE PROTECTED HEALTH INFORMATION

*Autorizacion para divulger y/o recibir informacion de salud protegia*

This authorization must be written, dated and signed by the patient or the person authorized by law to give authorization. If the person completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for service.

**To our families:** We are required by Federal Law to comply with the Health Insurance Portability and Accountability Act (HIPAA). We can help you better if we are able to work with other agencies/individuals that know your child and your family.

1

**I hereby authorize:** **(Medical office that is releasing your information)**

NAME OF SENDING OFFICE/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER

**To disclose to:** **(Medical office that is receiving your information)**

Central Oregon Pediatric Associates
NAME OF RECEIVING OFFICE/ORGANIZATION

2200 NE Professional Court
STREET ADDRESS

Bend Oregon 97701
CITY STATE ZIP CODE

541-389-6313 541-389-8760
TELEPHONE NUMBER FAX NUMBER

2

**Records and information pertaining to:**

PATIENT FULL LEGAL NAME DATE OF BIRTH (MM/DD/YYYY)

DAYTIME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

**INTERNAL USE:** (Records will be sent as the following)
☐ **Fax #541-389-8760**

3

**The released information will be used for the following purpose(s):**
☐ Personal Copy ☐ Continuity of Care ☐ Insurance ☐ Legal/Attorney ☐ Worker's Compensation ☐ Verbal Communication ☐ Other: _____

4

**Information to be disclosed ("X" each line to be disclosed):** *From* _____ *To* _____

| | | |
|---|---|---|
| _____ Chart Notes | _____ Birth History Forms | _____ Well Child Checks |
| _____ Hospitalizations | _____ Growth Grids | _____ Immunization Records |
| _____ Pathology Reports | _____ Laboratory Results | _____ Radiology Reports |

5

If the information to be used/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 used or disclosed if **I place my initials** in the applicable space next to the type of information:

| | |
|---|---|
| _____ **GENETIC TESTING INFORMATION** | _____ **STD, (HIV/AIDS) RECORDS & RESULTS** |
| _____ **MENTAL HEALTH INFORMATION** | _____ **BEHAVIORAL HEALTH INORMATION** |
| _____ **DRUG/ALCOHOL RECORDS** | |

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 6 months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. I understand that I do not have to sign this authorization in order to receive treatment from Central Oregon Pediatrics Associates. I have the right to refuse to sign this authorization. I also understand that when my information is used or disclosed pursuant to this authorization; it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the extent that Central Oregon Pediatrics Associations has acted in reliance upon it. My written revocation must be submitted to the Medical Records Clerk at Central Oregon Pediatrics Associates at 2200 NE Professional Ct, Bend Or. 97701

6

Finally, as is the case with respect to all personal representatives under the Privacy Rule and Oregon State Laws ORS 109.640, ORS 109.610, ORS 109.675, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes, in his or her professional judgment or that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

**RELATIONSHIP TO PATIENT:** ☐ Patient ☐ Parent ☐ Guardian ☐ Legal Custody

**SIGNATURE/*FIRMA*** **DATE/*FECHA***

**PRINTED NAME/*NOMBRE ESCRITO***