Instructions for the release of information *from* COPA

How to fill out COPA's "Authorization to Release Protected Health Information" form

Please note: If the patient is **15 years old or older**, they must complete and sign the authorization form.

1 Include **name, address** and **phone number** of the clinic or person receiving 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 how you would like to receive the records. Please include a clinic location if you are picking them up.

4 "X" the box to indicate the purpose of the records release

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

6 **Initial** beside each category you would like released. Only the categories you initial will be released. This information will not be released if you place an "X" on the line - you must initial.

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

8 Initial, indicating acknowledgment of associated fees.

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 PROTECTED HEALTH INFORMATION

Autorizacion para divulger informacion de salud protegi

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. I understand I am not required to sign this authorization to receive treatment. COPA is required by Federal Law to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Oregon Law.

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

Central Oregon Pediatric Associates
NAME OF SENDING 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

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

NAME OF RECEIVING OFFICE/ORGANIZATION/PERSON

STREET ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE 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

3 **Distribution:**

- ☐ **Fax #** _____
- ☐ **Mail paper copy to address above**
- ☐ **Pick up paper copy- location:** _____
- ☐ **Mail USB Drive to address above**
- ☐ **Securely email to:** _____
- ☐ **Upload to MyHealth Portal (if currently registered)**

4 **The released information will be used for the following purpose(s):**

☐ Personal Use ☐ Continuity of Care ☐ Legal/Attorney ☐ Verbal Communication ☐ Other: _____

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

____Chart Notes ____Sports Physical ____Well Child Checks ____Immunization Records
____Growth Charts ____Laboratory Results ____Radiology Reports ____Other _____

6 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 **_____HIV/AIDS TESTING AND RELATED INFORMATION**
_____MENTAL HEALTH RECORDS **_____SEXUALLY TRANSMITTED INFECTION (STI) TESTING AND TREATMENT**
_____ DRUG/ALCOHOL RECORDS **_____ REPRODUCTIVE HEALTH (contraception, pregnancy testing, etc.)**

7 This authorization will expire 6 months from the date of signature. I understand I may revoke this authorization at any time by providing written notice to COPA, except to the extent that action has already been taken based on it. I understand that my records may contain sensitive information protected by law. 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. ***NOTE:** Patients 14 years and older must authorize the release of medical records for specific treatment (See Section 6). Patients 15 years and older must authorize the release of medical records for general medical treatment.

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**

_____ _____
PRINTED NAME/*NOMBRE ESCRITO* **DATE/*FECHA***

AUTHORIZATION FOR RELEASE OF INFORMATION

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This authorization must be written, dated, and signed by the person authorized by law to give the authorization.
*Patients 14 years and older must authorize the release of medical records for specific treatment (See Section 6). Patients 15 years and older must authorize the release of medical records for general medical treatment.

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

Fees associated with this records request will be assessed in compliance with federal and state guidelines. For Personal or Legal use, there will be a charge of $25 for the first 10 pages and $0.25 per additional page, not to exceed the amount of $50. Records produced electronically or provided via USB drive will be charged at $15 per request. Please understand this request could take up to 30 days for processing.

_____ My initials indicate acknowledgement of the above fees, as they apply to my request.