

# Instructions for the release of information *to* COPA

How to fill out COPA's "Authorization to 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 receive. Only the categories you initial 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,



CENTRAL OREGON  
PEDIATRIC ASSOCIATES

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

## AUTHORIZATION TO RECEIVE PROTECTED HEALTH INFORMATION

*Autorización para recibir  
información de salud protegida*

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.

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**I hereby authorize:**

(Medical office that is releasing  
your information)

**To disclose to:**

(Medical office that is receiving  
your information)

NAME OF SENDING OFFICE/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER FAX NUMBER

Central Oregon Pediatric Associates (COPA)

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:**

**NOTE: Records should be faxed to: 541-389-8760**

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

DAYTIME PHONE NUMBER STREET

ADDRESS

CITY STATE ZIP CODE

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

☐ Personal Copy ☐ Continuity of Care ☐ Legal/Attorney ☐ Verbal Communication ☐ Other: \_\_\_\_\_

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

|                                            |                                              |                                               |
|--------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Chart Notes       | <input type="checkbox"/> Birth History Forms | <input type="checkbox"/> Well Child Checks    |
| <input type="checkbox"/> Hospitalizations  | <input type="checkbox"/> Growth Grids        | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Laboratory Results  | <input type="checkbox"/> Radiology Reports    |

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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:

|                                                      |                                                                                 |
|------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> GENETIC TESTING INFORMATION | <input type="checkbox"/> HIV/AIDS RECORDS & RESULTS                             |
| <input type="checkbox"/> MENTAL HEALTH INFORMATION   | <input type="checkbox"/> BEHAVIORAL HEALTH INFORMATION                          |
| <input type="checkbox"/> DRUG/ALCOHOL RECORDS        | <input type="checkbox"/> REPRODUCTIVE HEALTH (Contraception, STD testing, etc.) |

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 5). Patients 15 years and older must authorize the release of medical records for general medical treatment.

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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