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 RECEIVE PROTECTED HEALTH INFORMATION

Autorizacion para 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. 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)**

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 (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

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Records and information pertaining to:

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

DAYTIME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

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

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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* _____

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

_____GENETIC TESTING INFORMATION	**_____HIV/AIDS RECORDS & RESULTS**
_____MENTAL HEALTH INFORMATION	**_____BEHAVIORAL HEALTH INORMATION**
_____DRUG/ALCOHOL RECORDS	**_____REPRODUCTIVE HEALTH (Contraception, STD testing, etc.)**

This authorization will expire 1 year 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***