MORROW COUNTY HEALTH DISTRICT
Excellence in Healthcare

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I authorize **Morrow County Health District** to use and disclose a copy of the specific health information described below.

RECIPIENT

Name of person/entity			
Address	City	State	Zip

PURPOSE OF DISCLOSURE

At the request of the individual or:

DESCRIPTION OF INFORMATION TO BE DISCLOSED

If the information to be 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 disclosed if I place my **initials** in the applicable space next to the type of information.

- ☐ HIV/AIDS information
- ☐ Mental health information
- ☐ Genetic testing information
- ☐ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I understand that I have the right to refuse to sign this authorization. My refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean I will not receive health services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization. The only exception is when MCHD has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To **revoke** this authorization, please send a written statement to:
MCHD Medical Records, PO Box 9, Heppner, OR 97836

I have read this authorization and I understand it.

Unless revoked, this authorization will **expire** on _____.
(insert date or event)

_____ _____
Signature (individual or personal representative) Date

IF SIGNED BY PERSONAL REPRESENTATIVE ON BEHALF OF PATIENT

Relationship to patient
Description of personal representative's authority