Patient Chart Identification

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I hereby voluntarily authorize the release /disclosure of my confidential information from my health record as follow:

NAME OF PATIENT/CLIENT: DATE OF BIRTH:

II.

The information is to be disclosed by:		**And is to be provided to:**	
NAME OF FACILITY AND DEPARTMENT		NAME OF PERSON/ORGANIZATION/FACILITY	
ADDRESS	CITY/STATE	ADDRESS	CITY/STATE
PHONE #	FAX # (IF AVAILABLE)	PHONE #	FAX # (IF AVAILABLE)

III. **The purpose or need for this disclosure is:**

☐ Continuity of Care ☐ Attorney ☐ School ☐ Disability

☐ Personal Use ☐ Insurance ☐ Other *(Specify)* _____

IV. **The information to be disclosed from my health record**: *[check appropriate box(es)]*

☐ Period of events from _____ to _____

☐ Information related to *(specify)* _____

If you would like any of the following sensitive information disclosed, initial the applicable option(s) below:

_____ (Initials) Alcohol/Drug Abuse Treatment/Referral

_____ (Initials) HIV/AIDS-related Treatment

_____ (Initials) Sexually Transmitted Diseases

_____ (Initials) Mental Health records

V. You do not need to sign this authorization. Refusal to sign the authorization will not affect your ability to receive health care services or reimbursement for services. Refusal to sign means you will not receive health care services if they are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure. Your refusal to sign this authorization does not affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

This authorization may be revoked in writing at any time. To revoke this authorization, please send a written statement to the Privacy Officer, Northwest Human Services, 1233 Edgewater St NW, Salem, Oregon 97304, and state that you are revoking this authorization. Unless revoked earlier, **this authorization will <u>expire</u> on the following date, event, or condition**:

_____

(Date, event, or condition)

If no expiration date, event, or condition was specified, this authorization will expire 1 year from the date of signing.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

I have read this authorization and I understand it.

_____ (Date) _____ (Signature of Patient/Client or Personal Representative) _____ (Description of Personal Representative)

West Salem Clinic – Medical	West Salem Clinic – Dental	Total Health Community Clinic	Mental Health Clinic
1233 Edgewater St NW Salem, Oregon 97304 Phone: (503) 378-7526 Fax: (503) 480-1611	1233 Edgewater St NW Salem, Oregon 97304 Phone: (503) 378-7526 Fax: (503) 480-1595	180 Atwater Street N Monmouth, Oregon 97361 Phone: (503) 378-7526 Fax: (503) 480-1613	1233 Edgewater St NW Salem, Oregon 97304 Phone: (503) 378-7526 Fax: (503) 480-1614

NONDISCRIMINATION AND ACCESSIBILITY NOTICE

Discrimination is Against the Law

NWHS complies with applicable federal civil rights laws and does not exclude, deny services to, or otherwise discriminate against any individual based upon ethnic group identification, race, national origin, religious creed, age, sex, sexual orientation, gender identity or expression, veteran's status, color, disability, housing status, educational level, economic status, social class, political beliefs, linguistic preference, or reprisal or retaliation for prior civil rights activity in any program or activity.

We provide aids and services, free of charge, in a timely manner, to people with disabilities to communicate effectively with us, such as:
✓ Qualified sign language interpreters ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
We provide language services, free of charge, in a timely manner, to people whose primary language is not English, such as:
✓ Qualified interpreters ✓ Information written in other languages
If you need these services, call (503) 378-7526

If you believe that NWHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the NWHS Risk Officer located at 681 Center St. NW, Salem, OR 97301, Tel. (503) 588-5828, Fax (503) 588-5852. You can file a grievance in person or by mail, or fax. If you need help filing a grievance, the Risk Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail: attn.: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or phone 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-378-7526.	**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-378-7526.
繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-503-378-7526	**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-503-378-7526.
한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-503-378-7526번으로 전화해 주십시오.	**Українська (Ukrainian)** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-503-378-7526.
日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-503-378-7526 まで、お電話にてご連絡ください。	**العربية (Arabic)** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-503-378-7526.
Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-503-378-7526.	**ខ្មែរ (Cambodian)** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-503-378-7526 ។
Oroomiffa (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-503-378-7526.	**Deutsch (German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-503-378-7526.
فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-503-378-7526 تماس بگیرید.	**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-503-378-7526.
ภาษาไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-503-378-7526.	