Connie Umphred, R.N. (WA), Ph.D.

135 SE 1st Street, Pendleton, Oregon 97801
Ph: 541-278-2222
Fax: 541-276-8405

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ACCORDING TO ORS 192.520

I, _____ (Patient's name/Consenting Adult/Patient Representative)
authorize and request mutual exchange of protected health information from my clinical record between **Connie Umphred, R.N., Ph.D.** and

Name: _____

Mailing Address: _____

Phone: _____ **Fax**: _____

I authorize and request the mutual exchange of this specific information:
_____ **AT MY REQUEST** _____ **AT MY REQUEST FOR MY CHILD** _____
(Patient's name)

PATIENT'S DOB: _____

(Please initial next to each line of protected health information that you authorize disclosure of)

_____/_____**ALL RECORDS**, including:
_____/_____**HIV/AIDS** information
_____/_____**MENTAL HEALTH** information
_____/_____**GENETIC TESTING** information
_____/_____**DRUG/ALCOHOL DIAGNOSIS, TREATMENT OR REFERRAL**
_____/_____**OTHER**_____

For the purpose of:

(Please initial next to each one that applies)

_____/_____**AT MY REQUEST**
_____/_____**AT MY REQUEST FOR MY CHILD**
_____/_____**COORDINATION OF CARE AND TREATMENT**
_____/_____**PSYCHOLOGICAL/ NEUROPSYCHOLOGICAL TESTING/ ASSESSMENT**

This authorization will remain in effect until:
_____**DATE** or until revoked.

This authorization may be revoked in writing at any time. If this authorization is revoked, the information listed above will no longer be used or disclosed for the purposes described in this written authorization.

I understand that once information leaves this office, it is the responsibility of the recipient to protect the in formation according to the **ORS 192.520** and the **Health Insurance Portability and Accountability Act of 1996**.
I have read this authorization and understand it.

Patient Signature: _____ **Date:** _____

Representative Signature: _____ **Date**: _____
Representative Authority: _____

Witness Signature: _____ **Date:** _____

Revised 04/05/17