RELEASE OF INFORMATION (ROI)

GRANDE RONDE HOSPITAL AND CLINICS, PO BOX 3290, LA GRANDE, OR 97850
PHONE (541) 963-1446 FAX (541) 975-5220

Patient Info

Patient name: _____ Date of birth: _____

Personal representative: _____ Phone number: _____
(if applicable)

Recipient Info

For the above-named patient:

☐ Grande Ronde Hospital ☐ Regional Medical Clinic ☐ Specialty Clinic
☐ Women's/Children's Clinic ☐ Neurology Clinic ☐ Dermatology Clinic
☐ Elgin Clinic ☐ Union Clinic ☐ All GRH and Clinics ☐ Other

Name of individual or organization: _____

Address: _____ Email: _____

Contact number: _____ Fax number: _____

Purpose

This release is for the purpose of:

☐ Continuity of Care	☐ Transfer of Care	☐ Insurance
☐ Disability	☐ School Entry	☐ Legal
☐ At the request of the Individual	☐ Other _____	

Release Method

How would you like records released? ☐ Secure email ☐ Paper copy ☐ Electronic copy

To whom would you like your records released? ☐ Mail to patient ☐ Upload to MyChart ☐ Pick up by patient or recipient

Medical Records Requested

By **initialing** below, I authorize the release of the following medical records:

☐ Most recent 2 year medical record ☐ Clinic chart notes
☐ Laboratory reports ☐ Rehab Therapy
☐ Pathology reports ☐ Respiratory Therapy
☐ Radiology reports/images ☐ Billing statements
☐ ER notes ☐ Other _____

Date(s) associated with information requested: _____

By **initialing** below, I authorize the release of

_____Mental Health* _____Genetic Testing* _____HIV/AIDS-Related records*
_____Drug/Alcohol diagnosis, treatment, referral**

*If the information to be disclosed contains any of the types of records marked with an asterisk, additional laws relating to the use and disclosure of the information may apply.

I understand that this information will be disclosed only if I initial next to the requested information.
**Federal Regulation, 42 CFR Part 2 requires a description of how much and what kind of drug/alcohol-related information is to be disclosed.

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Limitations

This authorization is limited to the following:

Provider(s)/Department(s): _____

Time period: _____ Worker's Compensation claim: _____

Expiration and Revocation

This authorization may be revoked at any time by giving written notice to Grande Ronde Hospital and Clinics. The only exception is when action has been taken in reliance on the Authorization. If this Authorization has not been revoked, it will expire one year from the date of my signature unless a different expiration date or expiration event is stated. (Specify earlier expiration date or expiration event: _____.) To revoke this Authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information), and state that you are revoking this Authorization.

Understanding and Agreement

My signature below indicates that I understand and agree to the following:

1. *I understand that this is not a blanket authorization for release of information.*
2. *I understand that information used or disclosed to any entity may be subject to redisclosure by the recipient and no longer be protected by the standards for privacy of individually identifiable health information as set forth in 45 C.F.R. § 160 and 164. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.*
3. *I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization and that I may refuse to sign the authorization.*
4. *I understand that I am entitled to a copy of this authorization, and I acknowledge that the recipient will receive a copy of this authorization.*
5. *I understand that there may be circumstances that would allow Grande Ronde Hospital and Clinics to receive compensation for the release of my records.*
6. *I understand that this authorization is intended for one time use only. I must re-execute it should additional requests for information occur.*
7. *By authorizing the disclosure of my PHI, I understand that I may be authorizing disclosure of HIV-related information consistent with OAR 333-022-0210 and federal law.*
8. *I also understand that Oregon law allows HIV test information to be entered into my medical record and to be seen by, or shared orally with, persons who must review the record for the purpose delivering health care to me or for routine administrative purposes.*
9. *I further understand that Oregon law also requires my physician to report my identity and/or HIV antibody test results to public health authorities under certain circumstances without my authorization.*

Patient/Legal Representative Signature	Print Name	Date
Relationship to Patient		
Signature of Clerk	Verification Type	Date

Signatures

Authorization to Release Records to Patient Representative

I, _____, authorize _____ to receive my personal medical information.

Signature	Date