Oregon Health & Science University

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity disclosing information)

_____
(Address of person / entity)

_____
(City, State, Zip Code)

to use and disclose a copy of the specific health information described below regarding:

_____ _____
(Name of individual) (Date of Birth)

_____
(Address of Individual)

_____
(City, State, Zip Code)

consisting of:

x	History and physical examinations		Consultation reports
	Laboratory reports		Operative reports
	Discharge summary	x	X-ray/Diagnostic images
	Bioelectric output (i.e., EKG, EEG)		Tissue and/or blood specimens
x	Other, specify *MRI CD and report, genetics notes, neurology notes*		

to: *Attn: Leila Schwanemann, c/o Dr. Susan Hayflick*
(Name of recipient)
3181 SW Sam Jackson Park Road, Mail Code L103
(Address of recipient)
Portland, OR 97239-3098
(City, State, Zip Code)

for the purpose of: ***a research study at OHSU (IRB#** 10832)*
(Describe each purpose of disclosure / Insert IRB#)

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 only 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

This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services; however, your refusal to sign this authorization may affect your ability to participate in the research study.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

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 information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

Unless revoked, this authorization expires: *1 year after signature date* *(insert applicable date or event)*
(The statement "end of the research study" or "no expiration date" is sufficient for authorizations for use and disclosure of health information for research.)

By: _____ Date: _____
(Signature of individual or Legally Authorized Representative)

Description of relationship to individual: _____