Samaritan Health Services

Authorization to Disclose
Electronic Health Information in Computer Readable Export

Samaritan Health Services, Release of Information, P.O. Box 2728, Corvallis, OR 97339
Fax: 541-768-9363 Phone: 541-768-5069
SHSHIMROI@samhealth.org

Please see page 2 for instructions on how to fill out this form. An incomplete form can result in a processing delay.

PLEASE NOTE: The files in this export are not designed to be read by humans. The files in this export could be very large and take extra time to process. You will need an application that can use computer-readable data to understand these files.

1. PATIENT INFORMATION (PLEASE PRINT)

First Name, Middle Initial, Last Name			
List any other name you've used at any Samaritan facility or provider:			Date of Birth (MM/DD/YYYY)
Mailing address			Phone
City	State	Zip	Is it ok to leave a detailed message? ☐ Yes ☐ No

3. WHAT IS THE PURPOSE OF THIS REQUEST? (PLEASE SPECIFY) ☒ Patient Request - Electronic

4. WHAT DATE RANGE OF RECORDS DO YOU WANT? Date range cannot be prior to 01/01/2013.

From this date: ____/____/_____ To this date: ____/____/_____

5. I UNDERSTAND THAT I MUST INITIAL THE FOLLOWING ITEMS IF I WISH THIS INFORMATION TO BE RELEASED.

_____Mental health information/records _____HIV-positive test results and HIV diagnosis _____Genetic testing information/records	_____Drug/alcohol treatment or referral information. Per federal regulations, describe how much and what Drug/Alcohol information is to be disclosed: _____ _____

6. THIS INFORMATION IS TO BE RELEASED TO MYSELF (SELECT ONE)

Format:

☐ SHS MyChart Account

☐ CD (Choose one of the following)

☐ Call me at the phone number above to pick up CD ☐ Mail my CD to the address listed above

☐ **OR** release my CD to:

Person: _____

Phone: _____

7. MY RIGHTS: PLEASE REVIEW PAGE 2 FOR INSTRUCTIONS AND ADDITIONAL INFORMATION ABOUT YOUR RIGHTS.

I understand that refusal to sign the authorization will generally not negatively affect my ability to receive health care services or reimbursement for services. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected under federal law. I may be charged a reasonable, cost-based fee for copies of the medical records I request. This authorization may be canceled (revoked) at any time. Unless canceled, this authorization expires 12 months from the date I signed this form unless another date or event is specified here:_____

8. Signature of Patient or Patient Representative _____Date _____

Print Name if not Patient: _____Relationship to Patient: _____

☐ I am requesting a copy of this authorization form. ☐ Copy provided by _____ (Initials)

Samaritan Health Services

Authorization to Disclose Health Information - Instructions and Rights

Please print clearly. Not filling out the form completely may result in a delay in processing your request.

1. **PATIENT INFORMATION** - Print the patient's name, date of birth, mailing address and phone number.
2. **PURPOSE OF THIS REQUEST** - Please specify why you are requesting your medical information from the choices listed on page 1.
3. **WHAT RECORDS DO YOU WANT** - Please add a date range.
4. **SPECIAL MEDICAL RECORDS RELEASE** - There are specific types of records that require your specific authorization (permission) to release to someone other than yourself. If you want this information released, please initial each type that you want released. Alcohol and drug treatment records are protected under federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed by SHS or re-disclosed by those receiving this information without your written consent unless otherwise permitted by law.
5. **FORMAT OF RECORDS** - If you select ***SHS MyChart,*** records will be sent to your SHS MyChart account, and are available there for 90 days. In order to receive your information via MyChart, you must have an **active SHS MyChart account.** To learn more, visit samhealth.org/MyChart. If you select ***CD,*** you will receive password instructions with the CD.
6. **INFORMATION TO BE RELEASED TO** - Specify whether the requested information is being sent to the patient/patient representative or someone else. Be sure to include the complete address and phone number.
7. **MY RIGHTS**
   - **REFUSAL TO SIGN:** The only circumstance when refusal to sign means that you will not receive health care service is if the health care services are only for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
   - **CANCELLATION/REVOCATION:** This authorization may be canceled/revoked at any time. To cancel this authorization, send a written and signed statement to the Release of Information mailing address below and state that you are canceling this authorization. Canceling this authorization does not apply to information that has already been released.
8. **FEES**

Initial Patient Request	Reasonable cost-based fees apply in accordance with HIPAA and Oregon law

9. **SIGNATURE**
   - If the patient is 18 years of age or older, the patient must sign and date the form.
   - If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative may sign and date the form. Please indicate your relationship to the patient (Guardian, Health Care Representative or Health Care Power of Attorney) and include supporting documentation of your relationship.
   - If the patient is 17 years of age or younger, the patient's parent or legal guardian must usually sign and date the form. Please provide your relationship to the patient. If you are the patient's Legal Guardian, please include supporting documentation. In Oregon, minors may be able to request certain levels of confidentiality or consent to various health care matters depending on their age on their own. It is SHS policy to require the minor to authorize disclosure of those medical records.

Please send the completed Patient Request for Medical Records form to:

Mailing Address: Samaritan Health Services Health Information Management PO Box 2728 Corvallis, OR 97339	Fax: 541-768-9363 Phone: 541-768-5069 E-mail: SHSHIMROI@samhealth.org

Requests are processed in the order they are received.

Please allow up to 30 days to process requests. We make every effort to complete requests in a timely manner.

Health Information Management Customer Service Locations/Hours: Monday through Friday except holidays, 8:00 am to 4:30 pm

SHS HIM Corvallis	SHS HIM Albany	SHS HIM Lebanon	SHS HIM Newport	SHS HIM Lincoln City
3600 NW Samaritan Dr.	1046 Sixth Ave. SW	525 N. Santiam Hwy.	930 SW Abbey St.	3043 NE 28th St.
Corvallis	Albany	Lebanon	Newport	Lincoln City