PRINT Clear Form

Adventist Health Portland

OHSU Adventist Health Portland

MR1470

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN OHSU HEALTH MYCHART FOR ADVENTIST HEALTH PORTLAND PATIENTS

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

I _____ (Name of patient), hereby authorize Adventist Health Portland to disclose and provide access to health information about me in and through **OHSU Health MyChart**

to: _____
(*Name of authorized recipient*)

for the purpose of assisting and/or participating in my care. **I understand that authorizing disclosure and access to my health information to another individual by signing this form gives that other individual the same access I have to the health information and services available in OHSU Health MyChart.**

I understand that if I do not want Adventist Health Portland to disclose any of the below-listed types of information to my authorized recipient, I should not sign this Authorization form. I understand my receipt of health care services or reimbursement for services will not be adversely affected if I do not sign this Authorization form.

If I **do** wish to use the MyChart service by authorizing the above-identified person to receive and access **all** of my health information, including any HIV, mental health, genetic testing, and substance abuse information (whether or not such information exists or is contained in my records) I will place my ***initials*** in each and every space below:

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that by placing my initials in each of the spaces above, I am authorizing Adventist Health Portland to disclose and provide access to these types of information to the above-named authorized recipient.

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. 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 understand that I may revoke or cancel this Authorization in writing at any time. If I revoke or cancel this Authorization, my health information in the MyChart system may no longer be disclosed to or accessed by the person I have authorized. I understand that any uses or disclosures already made with my permission cannot be undone.

I have read this authorization and I understand it.

By: _____ Date: _____ Time: _____
(Signature of patient or personal representative)

Description of personal representative's authority: _____

This authorization expires upon the termination of the OHSU Health MyChart account unless revoked earlier. To revoke or cancel the Authorization, send a written statement to the clinic at which you originally received OHSU Health MyChart access, and state that you are revoking the Authorization. To immediately block access to your MyChart record, follow the procedure in the Mychart instructions.

MyChart

AUTHORIZATION TO DISCLOSE INFORMATION

INSTRUCTIONS:

The Authorization form allows Adventist Health Portland to provide to another person that you designate access to health information about you through the MyChart service. The Authorization is necessary in order for Adventist Health Portland to disclose certain types of information to someone other than you.

You do not need to sign the Authorization.

If you **do not** sign the Authorization, Adventist Health Portland will not be able to disclose your health information through the MyChart system to any person other than you.

If you **do** sign the Authorization, the MyChart service allows the person (that you designate and authorize to receive and access health information about you) to have access to **all** of the information about you that is maintained in MyChart . The MyChart service cannot block or prevent this other person (that you have authorized) from viewing select types or categories of information included in your health records, whether the information is about the time and date of your last appointment, results of a laboratory test, or information that may be specially-protected by law. Because MyChart cannot block or hide select categories or certain types of information (including information specially-protected by law that may be included in your MyChart records), you must authorize Adventist Health Portland to disclose and provide access to **all** of your health information in MyChart to the person you identify and authorize in order for Adventist Health Portland to make the MyChart service available to this other person (that you have authorized).

In Oregon, HIV, mental health, genetic testing and substance abuse information is specially-protected by law. Depending upon the circumstances, the law may require Adventist Health Portland to have specific permission to disclose this information. If you have any health information or records containing or referring to HIV, mental health, genetic testing, or substance abuse, the law may require that Adventist Health Portland have your specific permission to disclose this information before Adventist Health Portland can disclose or provide access to this information to certain persons other than you.

To effectively authorize Adventist Health Portland to disclose and provide access to **all** of your MyChart health information, you must specifically authorize Adventist Health Portland to disclose any HIV, mental health, genetic testing, and substance abuse information, whether or not such information exists or is included in your records. The Authorization form has spaces that you can initial to specifically authorize Adventist Health Portland to disclose this information.

If you do not sign this Authorization, your ability to receive health care services or reimbursement for services will not be affected. The only circumstance when refusal to sign an authorization will mean you will not receive health care services is if the health care services are solely for the purpose of providing health *information* to someone else (such as an employer or insurer), and the authorization is necessary for Adventist Health Portland to make that disclosure of *information*.

Your refusal to sign an Authorization cannot adversely affect your enrollment in a health plan or eligibility for health benefits, unless the disclosure of information to be authorized is necessary to determine if you are eligible to enroll in the health plan.

You may revoke or cancel the Authorization in writing at any time. If you revoke or cancel your Authorization, your health information in the MyChart system may no longer be disclosed to or accessed by the person you have authorized. Of course, any uses or disclosures already made with your permission cannot be undone.

To revoke or cancel the Authorization, please send a written statement to the clinic at which you originally received OHSU Health MyChart access, and state that you are revoking the Authorization. To immediately block access to your MyChart record, login to MyChart and click the “View Others Accounts” link that appears on your MyChart Homepage, and click the ‘Revoke Access’ link of the person of whom you’d like to cancel access (this type of cancellation is immediate)