Human Resources
155 N First Ave Ste 270 MS 11
Hillsboro OR 97124
(503) 846-8606
Confidential Fax Line:
(503) 846-3720

Patient must complete this section

Patient Name _____

Nickname/Maiden/Other _____

Health Record No. _____

Date of Birth _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Authorization of Health Care Provider to Use/Disclose Protected Health Information

I authorize the following Health Care Provider to release medical information related to my Health Care Provider Certification,

_____

NAME OF HEALTH CARE PROVIDER

Medical information disclosed is to be sent to WASHINGTON COUNTY HUMAN RESOURCES ONLY. Completed Health Care Provider Certifications should NOT be routed through employees department or direct supervisor through any form of transit.

I am applying for Family Medical Leave or ADA accommodation through my employer, Washington County. This information will be used for determination of FMLA/OFLA qualifying events or for information related to a reasonable accommodation.

Description of information to be used/disclosed (be specific as possible):

☐ Information related to _____

☐ Other (describe): _____

If the information to be used/disclosed contains any of the type 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 used or disclosed if I place my initials in the applicable space next to the type of information:

☐ Drug/Alcohol diagnosis, treatment _____

☐ Mental Health information _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that Federal or State law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information and genetic testing information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

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 purpose described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please contact the Health Care Provider stated above.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization will expire 90 days after the date signed.

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY