AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION TO THIRD PARTY APPLICATION/SOFTWARE DEVELOPERS FOR HEALTH INFORMATION SHARING AND MONITORING PURPOSES

INSTRUCTIONS

Instructions:

1. Provide this Authorization to Use and Disclose Protected Health Information to the patient to complete.
2. Answer questions about the intended access, use and disclosure of the protected health information (PHI) and how PHI will be shared.
3. If the PHI concerns: mental illness, developmental disability, HIV/AIDS testing or treatment, communicable disease, sexually transmitted disease, alcohol or drug abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, or genetic testing, then the patient or legal representative must sign a specific consent in addition to this Authorization.
4. Obtain the patient's or legal representative's signature.
5. Provide a copy of the completed, signed form to the patient and third party application/software developer.
6. Forward a copy of the completed signed form to Oregon Medical Group's Medical Records department.

IDENTIFYING INFORMATION

Medical Record Number or Account #: ____

Patient Name: ____

Last *First* *Middle*

Patient Date of Birth: Click here to enter a date.

Address: ____

Telephone Number: ____

PURPOSE

Purpose: I understand that this Authorization is not for the purpose of participating in, or conducting research and that I am consenting to and authorizing the access, use and disclosure of my past, present or future protected health information (PHI) listed below by Oregon Medical Group, its physicians and other health care providers (hereafter "OMG Clinicians") for the limited purpose of sharing healthcare monitoring information by: 1) the approved named recipients to Oregon Medical Group; and 2) from Oregon Medical Group to the approved named recipients. The purpose of the use and disclosure of my PHI is to facilitate: 1) Oregon Medical Group's care and treatment; 2) secure cloud based data storage of my healthcare monitoring information; and 3) my access to such health care monitoring information.

INFORMATION TO BE DISCLOSED

Specify information permitted to be disclosed: The information that may be accessed, used, and disclosed by OMG Providers under this Authorization expressly includes information in written, electronic, digital, or other recorded format (*be specific, check all that apply*):

- ☐ Description of condition or injury
- ☐ Testing and results
- ☐ Diagnosis
- ☐ Other (*describe*): ____________________________
- ☐ Clinical History
- ☐ Family History
- ☐ Demographic (age, sex, etc.)
- ☐ Treatment

RECIPIENT(S)

Approved Recipients: The following are individuals, groups or categories of people to whom OMG Providers may disclose my health information for the purposes set out in this Authorization (*check all that apply*):

Name of Entity/Individual: ____

Address: ____

Telephone and email address: ____

Website/Cloud address: ____

TERM AND REVOCATION
Term: This Authorization shall remain in effect and valid from the date it is signed **until** the following occurs: ☐ The date of Click here to enter a date. ☐ I revoke it in writing ☐ Three years after the date it is signed ☐ The following event occurs (*describe*): ____ **Revocation:** I understand and acknowledge that I have the right to revoke this Authorization at any time by providing **written** notice of my intended revocation to: the Oregon Medical Group Compliance and Privacy Officer at: 1580 Valley River Drive, Ste. 210, Eugene, OR 97401. **Effect of Revocation:** I understand that if I revoke this Authorization that my care and treatment, ability to receive care and treatment, or eligibility for health care benefits at Oregon Medical Group (OMG) will not be affected by my revocation. I also understand that revocation of this Authorization will not apply to the extent that OMG Providers have already accessed, used, or disclosed my health information in reliance on this Authorization and that once the health information has been published, or has been made public, revocation of this Authorization, as to that specific health information, is no longer possible.
OTHER ACKNOWLEDGMENTS
Acknowledgments: Read and initial before the paragraph below: ____ (*initial*) **Right to Refuse:** I understand I have the right to refuse to sign this Authorization and to refuse consent to the access, use, and disclosure of my health information for educational purposes. I also understand that my refusal will not affect my care and treatment at OMG or my eligibility for health benefits.
SIGNATURES
I have read and understand this Authorization and have had an opportunity to ask questions about the permitted access, use, and disclosure of the health information I have consented to in this Authorization and consent to each OMG access, use, or disclosure described herein. ____ Date: __________________ Signature of Patient or Legal Representative ____ Date: __________________ Name of Legal Representative (*if applicable*) ____ Date: __________________ Signature of Witness