HIPAA AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(ORS 192.522)

I, _____, authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of me or my health to use and disclose a copy of the specific health information described below regarding me consisting of any and all health information regarding me, including any financial, billing and insurance information directly related thereto to ElderCare Resources for the purpose of (initial those that apply):

Initials

___ Providing information about my condition and any prognosis for the future;
___ Providing services to me and on my behalf;
___ Helping to determine my mental competency;
___ Any court proceedings, including but not limited to guardianship and conservatorship proceedings involving me;
___ Any insurance or billing purposes or disputes.

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 if I place my initials in the applicable space next to the type of information:

Initials

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

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

I have read this authorization and I understand it. This authorization expires (check one):

( ) one year after the date it was signed
( ) two years after my death
( ) on (specify date) _____
Or upon my written revocation, delivered to the offices of ElderCare Resources, Inc.

By:_____ Date:_____

Individual or representative acting under valid legal authority

ElderCare Resources, Inc.
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