Oregon Board of Naturopathic Examiners
800 NE Oregon St., Suite 407
Portland, OR 97232
Phone (971) 673-0193
Fax (971) 673-0226

Authorization
To Use and Disclose Protected Health Information

Please complete this authorization form and return it to the Oregon Board of Naturopathic Examiners Office via fax or mail. A signed authorization to use and disclose protected health information form enables the Oregon Board of Naturopathic Examiners (OBNE) to review patient files during the course of an investigation of a complaint.

Name of person/entity disclosing information: This should have the name of the practitioner hospital or facility that has the patient records.

Name of individual: Name of patient whose records are to be released to the OBNE.

List the patient records you want copied and released to the OBNE: (Example: Chart notes, Prescription records, X-rays, Lab/Test Results, Billing records, or entire medical record) This should include all records that are pertinent to this investigation.

Records should be released to: Oregon Board of Naturopathic Examiners, 800 NE Oregon St., Suite 407, Portland, OR 97232 (this may be completed on the reverse)

Reason for disclosure: At the request of the Individual, or for purposes of conducting an investigation. Initial each of the listed records that OBNE may need to conduct this investigation.
To revoke this authorization you need to complete the contact information and forward to the same.

Authorization is revoked: Generally this should be 180 days or until investigation is completed.

Signature and date must be completed to be effective.

Should you have any questions please contact the Board office at 971.673.0193 or contact Anne Walsh, Executive Director at 971.673.0192.

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Please type or print neatly

I authorize, ______________________________ to use and disclose a copy of the
(Name of person/entity disclosing information)
specific health information described below regarding: ______________________________
(Name of individual)
consisting of (Describe information to be used/disclosed):
____
____

To: ______________________________
(Name and address of recipient or recipients)
for the purpose of (Describe each purpose of disclosure or indicate that the disclosure is at the request of the individual): ______________________________
____
____

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.

- ○ 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.

Provider 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 services 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 purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement stating that you are revoking this authorization:
____
(Contact person and address of person/entity disclosing information)
Signature: I have read this authorization and I understand it. Unless revoked, this authorization expires
______________ (insert either applicable date or event).
By: ______________________________ Date: ______________
(Individual or personal representative)
Description of personal representative's authority: ______________________________