

**LEWIS & CLARK COLLEGE'S  
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION - OREGON**

The Covered Entity may not use or disclose your protected health information except for purposes of treatment, payment, health care operations or other reasons permitted by law (please review the Entity's Notice of Privacy Practices for more information). You must authorize any other use or disclosure of your protected health information.

**Part 1. INDIVIDUAL'S INFORMATION**

Individual's Name:		Identification Number:	
Home Street Address:		Date of Birth:	
City:	State:	Zip Code:	Phone Number:

**Part 2. INFORMATION ABOUT THE USE or DISCLOSURE**

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I, the undersigned individual, hereby authorize the following Entity(ies) and its(their) business associates

**Persons authorized to provide Protected Health Information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

to release to the person listed below all information, including medical records, relating to the medical, physical, behavioral and mental condition, treatment, claims, billing and expenses of the individual identified in Part 1, which are held by you. I also authorize the release of documents related to application or authorization for medical services, case management records, utilization management records, and care coordination documents.

**Release my Protected Health Information to:**

Name: \_\_\_\_\_ Kris Codron, Benefits Manager \_\_\_\_\_ Phone Number: \_\_\_\_\_ 503-768-6237 \_\_\_\_\_

Address: Lewis & Clark College, 0615 SW Palatine Hill Rd. Portland OR 97219-7899

**Purpose for Disclosure: FMLA/OFLA Medical Certification for an Employee's Care for a Dependent with a Serious Health Condition**

The purpose of this authorization or request is to provide the personal health information of \_\_\_\_\_ (Dependent's Name) for the purpose of providing a medical certification to my employer that: \_\_\_\_\_ (dependent's name) has a serious health condition as defined by the Family and Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA) and it is necessary for me to be absent from work to provide care for \_\_\_\_\_ (dependent's name). The health care provider listed above is authorized to provide complete answers to all of the questions on the medical certification form that I have provided with this authorization or under separate cover. I will give the completed medical certification form to my employer for the purpose of complying with the company's medical leave policy and administering my FMLA/OFLA leave.

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                      \_\_\_\_\_ Genetic testing information  
\_\_\_\_\_ Mental health information                      \_\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information

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. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

**Expiration Date of Authorization:** \_\_\_\_\_ (indicate date, or an event relating to you or to the purpose of the authorization).

**Part 3. IMPORTANT INFORMATION ABOUT YOUR RIGHTS**

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

**Part 4. SIGNATURE of INDIVIDUAL or REPRESENTATIVE**

I hereby authorize the Entity and its business associates to use or disclose my protected health information as described in Part 2.

_____ Signature of individual or legal representative	_____ Date
_____ Printed name of individual's legal representative, if applicable	_____ Representative's relationship to individual

***\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\****