

PROTECTED HEALTH INFORMATION

192.518 Policy for protected health information. (1) It is the policy of the State of Oregon that an individual has:

(a) The right to have protected health information of the individual safeguarded from unlawful use or disclosure; and

(b) The right to access and review protected health information of the individual.

(2) In addition to the rights and obligations expressed in ORS 192.518 to 192.529, the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164, establish additional rights and obligations regarding the use and disclosure of protected health information and the rights of individuals regarding the protected health information of the individual. [2003 c.86 §1]

192.520 Health care provider and state health plan authority. A health care provider or state health plan:

(1) May use or disclose protected health information of an individual in a manner that is consistent with an authorization provided by the individual or a personal representative of the individual.

(2) May use or disclose protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) For the provider's or plan's own treatment, payment or health care operations; or

(b) As otherwise permitted or required by state or federal law or by order of the court.

(3) May disclose protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) To another covered entity for health care operations activities of the entity that receives the information if:

(A) Each entity has or had a relationship with the individual who is the subject of the protected health information; and

(B) The protected health information pertains to the relationship and the disclosure is for the purpose of:

(i) Health care operations as listed in ORS 192.519 (4)(a) or (b); or

(ii) Health care fraud and abuse detection or compliance;

(b) To another covered entity or any other health care provider for treatment activities of a health care provider; or

(c) To another covered entity or any other health care provider for the payment activities of the entity that receives that information. [2003 c.86 §3]

192.522 Authorization form. A health care provider may use an authorization that contains the following provisions in accordance with ORS 192.520:

**AUTHORIZATION
TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

I authorize: _____ (Name of person/entity disclosing information)
to use and disclose a copy of the 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 to _____
(contact person) at _____ (address of person/entity disclosing
information) and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires
_____ (insert either applicable date or event).

By: _____
(individual or personal representative)

Date: _____

Description of personal representative's authority: _____

[2003 c.86 §5]