Access to MyChart

Authorization to Release Medical Information

Patient Name: _____ DOB: _____ Former Name: _____

Current Address: _____ City: _____ State: ____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ SS#: _____

I Authorize the Release of Medical Information

FROM The Portland Clinic, To (Person to Receive Information):

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Purpose of Release: Access to MyChart Record

I understand that certain information cannot be released without specific authorization as required by state/federal law. I authorize the disclosure of all information maintained in my MyChart record. By initialing below I authorize the release of the following protected or sensitive information as it may pertain to me (the following items ***must be initialed*** to authorize access to your MyChart record):

____ AIDS/HIV test results including related high-risk behavior

____ Other sexually transmitted diseases

____ Mental health/treatment

____ Drug abuse diagnosis/treatment

____ Alcoholism diagnosis/treatment

____ Genetic testing

Federal and/or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information, and drug/alcohol diagnosis, treatment or referral information.

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will remain in effect for so long as I maintain a MyChart account. Although, if I am under the age of 18, this authorization will expire when I turn 18 years old.

The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing my health information to someone else, and this authorization is needed to make that disclosure. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

_____ _____ _____

Signature of Patient or Legally Responsible Person | Relationship to Patient | Date

_____

Print Name

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