192.521 Health care provider and state health plan charges. A health care provider or state health plan that receives an authorization to disclose protected health information may charge:

(1)(a) No more than $30 for copying 10 or fewer pages of written material, no more than 50 cents per page for pages 11 through 50 and no more than 25 cents for each additional page; and

(b) A bonus charge of $5 if the request for records is processed and the records are mailed by first class mail to the requester within seven business days after the date of the request;

(2) Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual; and

(3) Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual. [2003 c.86 §4; 2007 c.812 §1]

Note: See note under 192.518.

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]