OREGON VETERANS' HOMES

The Place Where Honor Lives

APPLICATION PACKET

IMPORTANT SUBMISSION INSTRUCTIONS

This OREGON VETERANS' HOME APPLICATION PACKET contains the forms required by the Oregon Department of Veterans' Affairs (ODVA) to apply for residency at one of the Oregon Veterans' Homes.

Included in this packet are the forms needed to apply for admission:

- ☐ Application for Admission, Form VH3000-1
- ☐ Notice of Privacy Practices, Form HP4000
- ☐ Authorization to Use and Disclose Protected Health Information (PHI), Form HP4001
- ☐ Acknowledgement of Receipt of the Notice of Privacy Practices, Form HP4002
- ☐ Authorization for Health Provider to Disclose Protected Health Information (PHI) to the Oregon Veterans' Home, Form HP4007

The following documents are also required to be submitted with this application as part of the admission process:

- ☐ The veteran's DD Form 214, Certificate of Release or Discharge from Active Duty (military discharge papers)
- ☐ VA Form 1010EZ Application For Health Benefits
- ☐ The current insurance card for the applicant
- ☐ A marriage certificate (only for spouses of veterans)
- ☐ Power of attorney, letters of conservatorship, and/or letters of guardianship (if applicable)

Submit all of the required documentation to:

THE DALLES: Admissions Coordinator Oregon Veterans' Home The Dalles 700 Veterans' Drive The Dalles, Oregon 97058-9757	LEBANON: Admissions Coordinator Edward C. Allworth Veterans' Home 600 North 5th Street Lebanon, Oregon 97355-2876

OREGON VETERANS' HOMES
The Place Where Honor Lives

APPLICATION FOR ADMISSION

Have you ever applied for admission to an Oregon Veterans' Home in the past?	
☐ Yes	☐ No

APPLICANT INFORMATION			
Name (Last, First, Middle)	Gender		
	☐ Male	☐ Female	☐ Other:_____

Social Security Number	Date of Birth (mm-dd-yyyy)	Religious Preference

Marital Status					
☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Never Married	☐ Other

Where are you admitting from?				Phone #	Fax #
☐ Home	☐ Hospital	☐ Nursing Home	☐ Other		

Home Address	City	State	Zip Code

County	Home phone	Mobile phone	Email Address

NATIONALITY/ ETHNIC BACKGROUND			
☐ Asian/Pacific Islander	☐ Black/African American	☐ Hispanic	☐ White/non-Hispanic
☐ Native American/ American Indian	☐ Other:_____		☐ Opt not to answer

STATUS INFORMATION		
Veteran Status	Resident of Oregon?	
☐ Veteran of U.S. Armed Forces	☐ Yes	☐ No
☐ Spouse or Surviving Spouse	☐ Yes	☐ No
☐ Parent who has lost a child to war-time service (Gold Star)	☐ Yes	☐ No

If you are not the veteran, complete the following information about the veteran:			
Name		Date of Birth (mm-dd-yyyy)	
Social Security Number		Date of Death (if applicable)	

APPLICATION FOR ADMISSION

VETERAN MILITARY SERVICE INFORMATION (all applicants must complete)				
Branch of U.S. Service				
☐ Air Force	☐ Army	☐ Coast Guard	☐ Navy	☐ Marine Corps
☐ National Guard/Reserves	☐ Other (specify):			
Period of Service				
☐ World War II	☐ Korean War	☐Vietnam	☐ Peacetime	☐ Persian Gulf
☐ Iraq/Afghanistan	☐ Other (specify):_____			
Character of Service				
☐ Honorable	☐ General, under honorable conditions	☐ Other:_____		
Service Number		Last Discharge Date	____ /____ / _____	
Does/did the veteran have a Service-Connected Disability?			☐ Yes	☐ No
If yes, percent	_____%			
VA Claim Number				
Does/did the veteran received medical care from the VA?			☐ Yes	☐ No
If yes, where?				

GENERAL INFORMATION FOR APPLICANT			
How did you hear about the Oregon Veterans' Homes?			
☐ Friend/family	☐ Website	☐ Media	☐ Other:_____

Does anyone have Power of Attorney or Conservatorship for you?	☐ Yes	☐ No
Is anyone a Guardian or Healthcare Power of Attorney for you?	☐ Yes	☐ No
Is anyone a Representative Payee for you?	☐ Yes	☐ No
Name of Responsible Person		
Relationship		

Address	City	State	Zip Code
Email Address	**Home phone**	**Mobile phone**	**Work phone**

APPLICATION FOR ADMISSION

INSURANCE INFORMATION FOR APPLICANT							
1	Medicare			1a	Number	1b	Medicare Part D
☐ Part A	☐ Part B	☐ Part C				☐ Yes	☐ No
2	Have you applied for Medicaid to cover the cost of your care?					☐ Yes	☐ No
2a	Caseworker Name						
2b	Caseworker Phone number						
3	Do you have supplemental medical insurance?					☐ Yes	☐ No
3a	Supplemental Medical Insurance #						
4	Do you have dental insurance?					☐ Yes	☐ No
4a	Dental Insurance #						
5	Have you been a resident in a nursing home in the last year?					☐ Yes	☐ No
5a	Facility Name(s)				Phone Number		Fax Number
6	Have you been hospitalized in the last year?				☐ Yes		☐ No
6a	Hospital Name(s)				Phone Number		Fax Number
Name of Personal Care Physician (PCP)/Specialists					Office phone		Fax Number

APPLICATION FOR ADMISSION

FINANCIAL INFORMATION				
NOTE: If you are receiving Medicaid benefits for payment of long term care, please skip the Financial Section of this form.				
MONTHLY INCOME			VETERAN	SPOUSE
Income from Farm/ Ranch/Business			$	$
Social Security Retirement/Disability			$	$
Non-Service connected Pension – A&A (or widow's pension)			$	$
Service Connected Disability Compensation			$	$
Military Retirement Pay			$	$
Retirement Income from Employer			$	$
Civil Service Retirement Income			$	$
U. S. Railroad Retirement			$	$
Rental Income from Rental Property			$	$
Income from Real Estate Contracts for Property Sold			$	$
Interest/Dividends (i.e. interest income from investments, standard income from non-tax deferred annuities)			$	$
Other income: _____			$	$
Other income: _____			$	$
TYPE OF ASSET	JOINT?		VETERAN	SPOUSE
	YES	NO		
Real Estate (primary residence)	☐	☐	$	$
Other Real Estate	☐	☐	$	$
Real Estate Contracts	☐	☐	$	$
Interest Bearing Checking Accounts	☐	☐	$	$
Interest Bearing Savings Accounts	☐	☐	$	$
Non-Interest Bearing Savings Accounts	☐	☐	$	$
Mutual Funds	☐	☐	$	$
Stocks & Bonds	☐	☐	$	$
Certificates of Deposit (CDs)	☐	☐	$	$
IRA/Keoghs/401K	☐	☐	$	$
Other Assets: _____	☐	☐	$	$
Other Assets: _____	☐	☐	$	$

APPLICATION FOR ADMISSION

ABUSE DISCLOSURE INFORMATION

According to the Federal Requirement on Abuse (42 C.F.R. §483.13(b)) …the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion.

Effective March 15, 1999, all potential admissions will be screened, via their medical records, for evidence of any history of abusive (physical, or verbal) behavior within the last three months.

Potential residents will not be admitted if their records indicate this type of behavior has been present within the last three months.

HIPAA AND AMERICANS WITH DISABILITIES ACT INFORMATION

The Oregon Department of Veterans Affairs (ODVA) complies with Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The ODVA privacy program policies ensure the privacy of residents and all information regarding protected health information (PHI).

ODVA complies with the Americans with Disabilities Act (ADA) PL101-336. The ADA provides that no qualified person with a disability shall be kept from participation in (or be denied a benefit of) the services, programs, or activities of ODVA because of that disability. For additional information or how to file a complaint, please contact ODVA's ADA Coordinator at 503-373-2380.

CERTIFICATION AND SIGNATURE

I fully understand all requirements that must be met and all qualifications that must be possessed for admission to the Oregon Veterans' Home.

I hereby certify that this application contains no willful misrepresentation or falsification and that the information given is true and complete to the best of my knowledge and belief.

I also understand that failure to supply this information may mean my eligibility cannot be determined.

SIGNATURE OF VETERAN OR RESPONSIBLE PERSON	DATE
✕	

OREGON DEPARTMENT of VETERANS' AFFAIRS

NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is the policy of the Oregon Department of Veterans' Affairs (ODVA) to protect the privacy of your personal information. This Notice of Privacy Practices (Notice) is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how ODVA may use or disclose your protected health information and with whom that information may be shared. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation. We will abide by and follow the HIPAA privacy practices that are described in this Notice while it is in effect.

CHANGES TO THIS NOTICE

ODVA reserves the right to change this Notice. Its effective date is shown above. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. To obtain a copy of the Notice of Privacy Practices:

- Access ODVA's website at www.oregon.gov/odva;
- Call ODVA at 1-800-828-8801 or 503-373-2373;
- Write to ODVA's Privacy Officer to have a copy mailed to you; or
- Ask for a copy the next time you visit ODVA.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You may be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. If you decline to provide a signed acknowledgment, ODVA may determine not to continue to provide you with requested services. ODVA will disclose your protected health information for treatment, payment, and health care operations when necessary.

WHICH PROGRAMS WILL FOLLOW THIS NOTICE

This Notice describes ODVA's practices regarding your protected health information. For this Notice, ODVA includes the following:

- ODVA's Veterans' Home Loan Program;
- ODVA's Claims, Counseling, Educational Aid, and Conservatorship Programs; and
- The Oregon Veterans' Homes.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

Protected Health Information is individually identifiable health information. This information relates to your past, present or future physical or mental health or condition and related health care services. ODVA is required by law to do the following:

- Make sure that your protected health information is kept private;
- Give you a copy of this Notice of our legal duties and privacy practices for the use and disclosure of your protected health information;
- Follow the terms of the Notice currently in effect;
- Communicate any changes in the Notice to you.

Other ways ODVA safeguards your personal health information:

- Treats all of your personal information that we collect as confidential;
- States confidentiality policies and practices in our employee handbook;

- Restricts access to your personal information to only those employees who need to know your personal information in order to provide services to you, such as approval for a home loan, or submitting a claim for a covered benefit;
- Discloses only your personal information necessary for a service provider to perform its functions on your behalf, and the provider agrees to protect and maintain the confidentiality of your personal information; and
- Maintains physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We only disclose your personal information when allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, **other than those listed below**, require your authorization. If there are other legal requirements that further restrict our use or disclosure of your personal information, we will comply with those legal requirements as well. Following are types of disclosures allowed or required by law.

TREATMENT: ODVA may use your medical information to provide you with access to medical treatment or services. We may disclose your medical information to doctors, nurses, or health care providers who are involved in your treatment. Treatment activities include disclosing your personal information to a provider in order for that provider to treat you. For example, we will disclose your protected health information, as necessary, to the Health Care Professionals who provide care at the Oregon Veterans' Home. We may disclose your protected health information to the U.S. Department of Veteran's Affairs (USDVA). **IN EMERGENCIES,** ODVA will use and disclose your protected health information to assist you in obtaining treatment.

PAYMENT: ODVA may use and disclose your medical information so that the treatment and services you receive may be properly billed and paid. For example, ODVA may use your medical information from surgery you received at a hospital so the hospital can be reimbursed. We may also use your information to obtain prior approval for treatment.

HEALTH CARE OPERATIONS: ODVA may use and disclose your protected health information to support activities related to your health care. ODVA will share your protected health information with third-party business associates who perform various activities (for example, billing or transcription services) for ODVA.

DEATH; ORGAN DONATION: ODVA may disclose protected health information of a deceased person to a coroner, funeral director, or organ procurement organization for certain purposes. For example, we may disclose protected health information to a funeral director to enable them to carry out their duties.

LEGAL PROCEEDINGS; CRIMINAL ACTIVITY: ODVA may disclose protected health information during any judicial or administrative proceeding, in response to a court order, subpoena, discovery request, or other lawful process. For example, if you are a victim of a crime or you commit a crime, ODVA may disclose information to law enforcement.

MILITARY ACTIVITY AND NATIONAL SECURITY: ODVA may also disclose your protected health information to authorized officials conducting national security and intelligence activities.

PUBLIC HEALTH AND SAFETY: ODVA may disclose your protected health information if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. For example, we may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or other crimes.

REQUIRED USES AND DISCLOSURES: By law, ODVA must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. The following are examples in which your agreement or objection are required:

- ODVA will use and disclose in the Oregon Veterans' Home inpatient directory the resident's name, condition (in general terms), and religious affiliation. This information, except religious affiliation, will be disclosed to people who ask for the resident by name. Only members of the clergy will be told a resident's religious affiliation.
- ODVA may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, general condition, or disposition upon death.

EXERCISING YOUR RIGHTS – You may exercise the following rights by submitting a request to ODVA's Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. ODVA's Privacy Officer can guide you in pursuing these options. Please be aware that ODVA may deny your request; however, you may seek a review of the denial.

- **Inspect and Copy** – You have the right to inspect and obtain a copy of your protected health information that ODVA maintains in a "designated records set". A designated record set contains medical and billing records which ODVA uses for making decisions about you. ODVA may charge you a nominal fee for providing you with copies of your protected health information.
- **Restriction Requests –** You have the right to request that ODVA place additional restrictions on our use or disclosure of your protected health information for treatment, payment, health care operations, or to persons you identify. Your request must be in writing to ODVA's Privacy Officer. ODVA is not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency or as required by law.
- **Request Confidential Communications –** You may request that we communicate with you using alternative means or at an alternate location. We will accommodate reasonable requests, when possible.
- **Amendment** – If you believe that the information ODVA has about you is incorrect or incomplete, you may request an amendment to your protected health information. Your request must be in writing and it must identify the information that you think is incorrect and explain why the information should be amended. While ODVA will accept requests for amendment, we are not required to agree to the amendment. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Accounting of Disclosure** – You have the right to receive a list of instances in which we disclose your protected health information for purposes other than those described in "HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION" earlier in this Notice. You are entitled to this accounting for the 6 years prior to your request, though not for disclosures made prior to April 14, 2003. ODVA will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, ODVA may charge you a reasonable fee for responding to these additional requests.

FEDERAL PRIVACY LAWS

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act, and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with ODVA's Privacy Officer, the Governor's Office, or the U.S. Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

CONTACT ODVA FOR INFORMATION

You may contact ODVA's Privacy Officer for further information about the complaint process, or for further explanation of this document. ODVA's Privacy Officer may be contacted at ODVA, 700 Summer St. NE, Salem OR 97301-1285, or by phone at 503-373-2000 or toll-free at 1-800-828-8801 (Inside Oregon Only).

ODVA intends to comply with the Americans with Disabilities Act (ADA), PL101-336. The ADA provides that no qualified person with a disability shall be kept from participation in (or be denied a benefit of) the services, programs, or activities of ODVA because of that disability. For additional information or how to file a complaint, please contact ODVA's ADA Coordinator at 503-373-2380.

This information is also available in alternate formats, upon request.

OREGON DEPARTMENT of VETERANS' AFFAIRS

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

VETERAN/CLAIMANT INFORMATION

Veteran Full Name *(Last, First, Middle)*			Veteran Date of Birth	Veteran SSN	Veteran VA Claim No.
Military Service No.	Service Branch	Conservatorship No.	Educational Aid No.	ODVA Loan No.	OVH Resident No.
Claimant Full Name *(if other than Veteran)*		Relationship to Veteran	Claimant Date of Birth	Claimant SSN	Claimant VA Claim No.

DISCLOSURE INFORMATION

I authorize the Oregon Department of Veterans' Affairs (ODVA) to use and disclose a copy of the specific health information described below regarding the above-named veteran/claimant, which consists of *(describe information to be used/disclosed)*:

- ☐ any information to fully adjudicate a claim
- ☐ any necessary protected health information (PHI)
- ☐ any and all protected health information (PHI)

to *(provide name and address on separate page)*:

- ☐ the U.S. Department of Veterans Affairs (USDVA), including, but not limited to, the Veterans Benefits Administration, Veterans' Health Information, VA Veteran Centers, VA Vocational Rehabilitation, Board of Veterans' Appeals, and VA Cemetery Systems, etc.
- ☐ various benefit providers and other entities as needed
- ☐ any and all health care providers
- ☐ insurance providers
- ☐ Veteran Service Officer

for the purpose of *(describe each purpose of disclosure)*:

- ☐ preparation, presentation, and prosecution of a claim.
- ☐ fulfilling a court-appointed fiduciary obligation.
- ☐ providing medical care, client billing, insurance billing, and obtaining benefits for the veteran/claimant from the USDVA, the Oregon Department of Human Services and the Department of Health Services.

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
_____ Mental health
_____ Genetic testing
_____ Drug/Alcohol diagnosis, treatment, or referral

AUTHORIZATION AND SIGNATURE

I understand that signing this authorization is voluntary. Refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement for services. 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 health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization does not adversely affect my enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone.

To revoke this authorization, I will send a written statement to the attention of: ODVA Privacy Officer, 700 Summer Street NE, Salem, Oregon 97301-1285, and state that I am revoking this authorization.

Unless revoked, this authorization expires on the following date or event:

- ☐ Discharged from Veteran Home
- ☐ Years:
- ☐ Termination of Power of Attorney
- ☐ Death
- ☐ Termination of Conservatorship
- ☐ Does Not Expire
- ☐ Date:
- ☐ Resolution or Completion of Claim
- ☐ Written Revocation

- ☐ I have received a copy of ODVA's Notice of Privacy Practices.
- ☐ 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.
- ☐ I have read this authorization and I understand it.

Signature	Date Signed

Description of personal representative's authority *(if applicable)*:

- ☐ Spouse
- ☐ Power of Attorney
- ☐ Court-appointed Guardian
- ☐ Other:

OREGON DEPARTMENT of VETERANS' AFFAIRS

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

The Oregon Department of Veterans' Affairs (ODVA) Form **HP4000 THE NOTICE OF PRIVACY PRACTICES** tells you how ODVA may use and disclose information about you. Not all situations will be described. ODVA is required to give you a notice of our privacy practices for the information we collect and keep about you.

ACKNOWLEDGEMENT AND SIGNATURE

(To be completed and signed by the individual receiving the Notice of Privacy Practices)

☐ I have been given a copy of ODVA's Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

VETERAN/CLAIMANT INFORMATION *(if other than Veteran)*

Printed Veteran Name *(Last, First, Middle)*			Veteran Date of Birth	Veteran SSN	Veteran VA Claim No.
Military Service No.	Service Branch	Conservatorship No.	Educational Aid No.	ODVA Loan No.	OVH Resident No.
Printed Claimant Name *(Last, First, Middle)*		Relationship to Veteran	Claimant Date of Birth	Claimant SSN	Claimant VA Claim No.

SIGNATURE

Signature	Date Signed

Description of personal representative's authority *(if applicable)*:

☐ Spouse ☐ Power of Attorney ☐ Court-appointed Guardian ☐ Other:

OREGON DEPARTMENT of VETERANS' AFFAIRS

AUTHORIZATION FOR HEALTH PROVIDER TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO THE OREGON VETERANS' HOME

VETERAN/CLAIMANT INFORMATION

Printed Veteran Name *(Last, First, Middle)*			Veteran Date of Birth	Veteran SSN	Veteran VA Claim No.
Military Service No.	Service Branch	Conservatorship No.	Educational Aid No.	ODVA Loan No.	OVH Resident No.
Printed Claimant Name *(if other than Veteran)*		Relationship to Veteran	Claimant Date of Birth	Claimant SSN	Claimant VA Claim No.

DISCLOSURE INFORMATION

I authorize *(Provider)*:

to disclose a copy of specific health information regarding *(Name of Veteran or Claimant)*:

and consisting of any and all medical information for the past six months to:

☐ Oregon Veterans' Home The Dalles
700 Veterans' Drive
The Dalles, Oregon 97058-9757

☐ Edward C. Allworth Veterans' Home
600 North 5th Street
Lebanon, Oregon 97355-2876

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

_____ Genetic testing

_____ Mental health

_____ Drug/Alcohol diagnosis, treatment, or referral

NOTICE TO THE PROVIDER

The undersigned may revoke this authorization in writing at any time. If the authorization is revoked, the information described above may no longer be disclosed to the Oregon Veterans' Home for the purposes described in this written authorization. To expedite the disclosure of PHI to the Oregon Veterans' Home, the signer below has authorized disclosure prior to signing your individual authorization form.

SIGNATURE AND AUTHORIZATION

Unless revoked, this authorization expires on the following date or event:

☐ Date:

☐ Discharged from Veteran Home ☐ Termination of Power of Attorney ☐ Termination of Conservatorship ☐ Resolution or Completion of Claim

☐ Years: ☐ Death ☐ Does Not Expire ☐ Written Revocation

☐ 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.

☐ I have read this authorization and I understand it.

Signature	Date Signed

Description of personal representative's authority *(if applicable)*:

☐ Spouse ☐ Power of Attorney ☐ Court-appointed Guardian ☐ Other: