Audit Report Release Form
for the Jefferson Health Information Exchange (JHIE)

Please complete this form in its entirety, including all required signatures (front and back of the form).

Initial that you have read and understand the following statement:

_____ I hereby authorize JHIE to release to me an audit report that summarizes access to and disclosure of my protected health information through the health information exchange.

Initial

Please complete the following information for the patient for which an Audit Report is being requested:

First Name: _____ Middle Name: _____ Last Name: _____

Previous/Maiden Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Please indicate if there is a specific reason or concern for which you are requesting an audit report so that JHIE staff can follow up with you.

_____

_____

_____

How do you prefer to receive your audit report?

- ☐ Paper copy mailed to address (mailing address must be provided above)
- ☐ Pick up in-person at the JHIE office (date/time for pickup will be scheduled via phone or email)
- ☐ In a secure email (email address must be provided above)

Patient Signature: **X** _____ Date Signed: _____

If the patient is between 14 to 18 years of age their signature is required (reverse side of this form).

JEFFERSON HEALTH INFORMATION EXCHANGE

A patient between 14 – 18 years of age may request an Audit Report without the signature of a parent or legal guardian. If the patient is under 14 years of age, signature of parent or legal guardian is required, and the identity of the parent/guardian must also be verified. See Page 2 (on the reverse of this form).

Parent Signature: **X** _____ Date Signed: _____

Print Name: _____

Relationship to Patient: _____

For your protection, we must verify your identity in order for JHIE to process the *Audit Report Request*.

Your identity may be verified one of three ways: have this form signed by a Notary Public or by a Health Care Provider licensed by the State of Oregon, or present a valid driver's license or other government-issued photo identification to staff at the JHIE office.

This section to be completed by a Notary Public or Licensed Health Care Provider to verify the identity of the patient requesting an Audit Report:

I witnessed the above named individual sign this document and the individual is personally known to me and/or provided me with valid picture identification on this day ____of_____, 20____.
Day **Month** **Year**

Notary or Provider
Print Name: _____ Phone Number: _____

Notary or Provider
Signature: **X** _____ Date Signed: _____
Must be an original signature in black or blue ink.

<u>If patient is under 14 years of age</u>, this section is to be completed by a Notary Public or Licensed Health Care Provider to verify the identity of the patient's parent/guardian:

I witnessed the above parent/guardian sign this document and the individual is personally known to me and/or provided me with valid picture identification on this day ____of_____, 20____.
Day **Month** **Year**

Notary or Provider
Print Name: _____ Phone Number: _____

Notary or Provider
Signature: **X** _____ Date Signed: _____
Must be an original signature in black or blue ink.