Oregon Medical Group Authorization To Use/Disclose Health Information

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization*.

Patient name (Printed) _____ Alternate Names Used _____ DOB _____

Address _____ City _____ State _____ Zip _____ Phone Number _____

I authorize information to be released:

From: _____ _____
Individual or Facility Phone Number

_____
Mailing Address, City/State, Zip

To: _____ _____
Individual or Facility Phone Number

_____
Mailing Address, City/State, Zip

The purpose of this request is:

- ☐ Referred Medical Care (Specialist)
- ☐ Transferring Primary Care
  - ☐ Relocation
  - ☐ Personal Preference
  - ☐ Other _____
- ☐ Clinical Research
- ☐ Billing Purposes
- ☐ Personal Request
- ☐ Other _____

The purpose of this request is at the request of the individual.

TYPE OF INFORMATION TO BE RELEASED:

_____ *All Medical Records (Last 2 years of information unless otherwise indicated)
_____ *Entire Record (Birth to Present unless otherwise indicated)
_____ Physician Notes
_____ Imaging Reports and/or Films **(circle one or both)**
_____ Lab and/or Pathology Reports **(circle one or both)**
_____ Hospital Records/Consultations
_____ Physical Therapy Records
_____ Worker's Comp Injury Records
_____ Immunization Records
_____ Billing Information
_____ Other _____

Must be initialed to be included in other documents

_____ HIV/AIDS – related records

_____ Mental Health Counseling and/or treatment information, including information regarding Depression, Anxiety and Stress.

_____ Genetic Testing Information

_____ Drug/alcohol diagnosis, treatment or referral Information (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of info is to be disclosed). If applicable complete restriction box below

* "Entire Record" and "All Medical Records" include **ALL** Billing, Imaging, and Medical record information.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at Oregon Medical Group, P.O. Box 1648 Eugene OR. 97440, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Restrictions - Initial & Complete if applicable:

_____ This authorization is limited to the following time period: _____
_____ This authorization is limited to the following treatment: _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I specifically give authorization to FAX my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information. _____**(initials)**

Signature of patient or legally responsible person* _____ **Relationship to Patient** _____ **Date** _____

*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)