CENTRAL OREGON FAMILY MEDICINE

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

I authorize ____________________________________ ____
(Name of Facility or Provider Disclosing Information) (Address)

____________________________________ ____
(Phone) (Fax)

To use and disclose a copy of the specific health information described below regarding:

______________________________________ ______________ ____________________ ________________
Patient Name Date of Birth Social Security Number Phone #

This information is to be released to:

____________________________________ ____
(Name of Facility or Provider Receiving Information) (Address)

____________________________________ ____
(Phone) (Fax)

*****For the purpose of: (Describe purpose of EACH disclosure)** _____________________________________

By **initialing** the space below, I specifically authorize the release of the following medical records, if such records exist:

_____Chart Notes _____Lab Results _____Billing Statements

_____Other (please specify ____

_____ All medical records for continuity of health care

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use of the highly confidential information may apply. I understand and agree that this **highly confidential information** will be disclosed if I place **my initials** in the applicable space.

_____ HIV/AIDS related records _____ Mental health information _____ Drug/alcohol diagnosis, treatment or referral information
_____ Genetic testing information _____ Psychotherapy Notes

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:

- Creating health information about you to be disclosed to a third party; or
- For the purpose of research.

I understand that the information disclosed pursuant to this authorization may be re-disclosed and no longer protected if the recipient is not subject to federal privacy regulations.

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 Central Oregon Family Medicine that identifies the date you signed this Authorization, the recipient of the information identified in this authorization, and states that you are revoking this Authorization.

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

I have read this authorization and I understand it.

______________ ______________________________________ ____________________________________
Date Signature of Patient or Personal Representative Description of Personal Representative