ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
www.rogueriverfpc.com
541-582-0505

AUTHORIZATION

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

I (name of patient and date of birth) _____, authorize _____ to use and/or disclose my health information as identified below to:

Name and address of recipient: _____

_____

_____

_____

Phone _____

The information will be used on my behalf for the following purpose(s) _____.

By initialing the spaces below, I specifically authorize the release of the following medical records, if they exist.

- ☐ Please send the entire medical record (all information) to the above named recipient.
- ☐ All hospital records (including nursing records and progress notes)
- ☐ Most recent five-year history
- ☐ Clinician office chart notes
- ☐ Transcribed hospital records
- ☐ Dental records
- ☐ Medical records needed for continuity of care
- ☐ Physical therapy records
- ☐ Laboratory reports
- ☐ Emergency and urgent care records
- ☐ Pathology reports
- ☐ Billing statements
- ☐ Diagnostic imaging reports
- ☐ Other _____

SEPARATE, SIGNED AUTHORIZATION FORM REQUIRED FOR THE FOLLOWING:

- HIV/AIDS related records
- Genetic testing information
- Mental health information
- Dug/ alcohol diagnosis, treatment or referral information

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time giving written notice to Rogue River Family Practice Clinic. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon _____. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may re disclosed and no longer be protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____

SIGNATURE OF PATIENT (OR PATIENT'S LEGAL REPRESENTATIVE) DATE

_____ _____

PRINT NAME OF LEGAL LEPRESENTATIVE (IF APPLICABLE) RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT