



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.

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

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information:

- | | |
|--|---|
| <input type="checkbox"/> HIV/AIDS related records | <input type="checkbox"/> Mental health information |
| <input type="checkbox"/> Genetic testing information | <input type="checkbox"/> Drug/ 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 be 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 REPRESENTATIVE (IF APPLICABLE)

RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT