AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

______________________________________ ____________________________________
(Name of Patient) (Date of Birth)

I hereby authorize the release of medical information regarding the patient named above by copy of medical records and/or by discussing the information in person or by phone.

Consisting of: Chart Notes_____________ Labs/pathology_______________ Imaging _____________

Date of range of Information needed: Current Records _______ last 5 years_________
All Records_________

Purpose of Need for this Information: Continuing care_________ Copies for own use_________
Other____________________

From: ____
Address____
City, State, Zip Code ____
(Phone) ___________________________________ (Fax) _______________________________________

TO: HARRISON FAMILY MEDICINE

1100 Southgate Suite 2
Pendleton, Oregon 97801
(phone) 541-215-1564
(fax) 541-215-1567

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

___________HIV/AIDS information____________Mental health information___________Genetic testing information

___________Alcohol/Chemical Dependency diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services if the health care services represent research related treatment and the authorization is necessary to participate in the research study and received research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Melanie Contor at 1100 Southgate Ave Pendleton, Oregon 97801 and state you are revoking this authorization.

Unless revoked, this authorization expires in one (1) year from the date of signing and shall remain in effect for the period reasonably needed to complete the requirement.

By: ____ Date: ________________________________