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 _____

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:

_____ HIV/AIDS related records
_____ Genetic testing information
_____ Mental health information
_____ 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 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