**AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON:  Personal  Medical Care  Benefits  Litigation  Workman’s Comp  Permanent Transfer  Other: \_\_\_\_\_\_\_\_\_\_

**I AUTHORIZE INFORMATION RELEASE *FROM*:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Facility or Provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Fax

**INFORMATION TO BE RELEASED *TO*:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Facility, Provider or Individual

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Fax

**Type of Information to be Released – Please check appropriate box(s)**

🗆 **Specific Information Only Please**

 🗆 Chart Notes 🗆 Immunization Records 🗆 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🗆 Laboratory Results 🗆 Medications Records 🗆 Mammogram 🗆 Diagnostic Images/Reports 🗆 Physical Therapy 🗆 Colorectal Cancer Screening (Colonoscopy)

🗆 **(For Desert Orthopedics ONLY) on disc $10 X-Ray $15 MRI $15 Both MRI/X-Ray**

🗆 **Most Recent Visit** 🗆 **Medical records from \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_** 🗆 **Last 2 years only** - includes 2 years chart /progress notes and last 3 labs or 50 pages, whichever is greater, plus current medications, allergies, active problem list and vaccine history.

***Note: If no checkbox is selected, last 2 years will be sent -* COPY/POSTAGE FEES UP TO $50 MAY APPLY FOR MORE THAN 2 YEARS.**

**Protected or Sensitive Information**

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

Initials

\_\_\_\_\_\_ Mental health/Psychotherapy notes/Neuropsychological Results

Initials

\_\_\_\_\_\_ Genetic testing information

Initials

\_\_\_\_\_\_ Drug/Alcohol diagnosis, treatment, or referral information

Initials

***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.***

* 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 have copies of 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 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.
* This authorization will remain in effect for *one year* from the date of signature unless a stop date is identified.
* I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640.  [insert applicable date or event of expiration]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Patient or Patient’s Legal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name or Name of Patient’s Legal Representative (if applicable) Relationship to Patient