



Authorization to Release and Receive Protect Health Information

Patient Full Name: _____ **Date of Birth:** _____

I hereby Authorize: West Bend Family Medicine

- To **SEND** a copy of the specific health information described below regarding:
- To **RECEIVE** a copy of the specific health information below regarding:

Clinic/Facility Name			
Phone Number		Fax Number	
Address:			

Please specify which records to release:

<input type="checkbox"/>	CHART NOTES	From _____	To _____	
<input type="checkbox"/>	LAB RESULTS	From _____	To _____	Name of Test/study _____
<input type="checkbox"/>	RADIOLOGY	From _____	To _____	Name of Test/study _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws related to the use and disclosure of the information may apply. I understand that initialing in the applicable space next to the type of information authorized the release of that information.

- _____ **GENETIC TESTING**
- _____ **SEXUALLY TRANSMITTED DISEASE (including HIV/AIDS)**
- _____ **MENTAL AND BEHAVIOR HEALTH RECORDS**
- _____ **DRUG / ALCOHOL TREATMENT**

This authorization may be revoked at any time, except when the action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 1 year from the date of signing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer can be protected under federal law. This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization. If the individual completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for services.

By Signing Below, I acknowledge that this document was given to me in a language I understand either in writing or as read to me in its entirety.

Patient Signature: _____ **Date:** _____

Parent/legal Guardian: _____ Date: _____

Medical Records Policy

The purpose of this policy is to ensure that our patients’ medical records are not released to any unauthorized individuals. Develop a tracking system to document an accounting of disclosures to be compliant with HIPAA.

- Medical records can be released to healthcare providers who are participating in your care under continuity of care regulations. If we have referred you to another doctor, we will send them your records prior to your appointment.
- You can request a copy of your own medical record. A medical release form must be used. NO Emails or telephone/verbal requests can be made. We get your signature for your protection.
- Patients are the only ones who can authorize release of records – not spouses, grown children or friends, unless they have power of attorney or are the guardian of a minor.
- West Bend Family Medicine is aware that HIPAA does not require written consent for all releases of medical information but chooses to implement this policy to ensure the confidentiality and privacy of our patients.
- Due to the transition to a new electronic medical record system, West Bend Family Medicine will make reasonable efforts to ensure that a complete medical record is disclosed. However, despite such efforts, there may be instances in which certain documents are unavailable or omitted.
- Requests for medical records may take up to 30 days to process.
- We may charge a reasonable fee to offset the costs associated with specific categories of requests. Assessments of fees are based on such factors as the cost of equipment and supplies, employee costs, and administrative overhead and shall include postage, including express mail costs when incurred at the request of the authorizing party. The state of Oregon has set out a fee schedule of charges for medical records. We determine our charges based on this fee schedule. We reserve the right to waive this fee given certain circumstances.
- The Omnibus Rule, effective 9/23/2013, “allows for the identification of labor costs for copying protected health information, whether in paper or electronic form., which ca include a reasonable cost-based fee for time spent creating and copying the file.” The lab for copying medical records varies from state to state based on the statute passed by each state’s legislation. Below are the current fees for the State of Oregon:

Pages 1-10: \$30 Flat Fee Pages 11-50: \$0.50 per Page Pages 51+: \$0.25 per Page	Bonus Fee: \$5.00 if processed within 7 days	Postage: Actual cost of mailing
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2017 ORS 192.563

<https://www.oregonlaws.org/ors/192.563>

*Fees are subject to change based on new laws passed in each state throughout a calendar year