Release of Records: Authorization to Use and Disclose Protected Health Information

This authorization must be written, dated and signed by the patient or by a person authorized by law to release this information.

I authorize:

Name of Previous Medical Facility/ Medical Provider of Records _____

_____

Address of Facility/Provider_____

Phone_____Fax_____

To use and disclose a copy of the specific health information described below regarding:

PRINT Patient Full Name_____Date of Birth_____

This information is to be released to:

WEST BEND FAMILY MEDICINE
2855 NW CROSSING DRIVE #102
BEND, OR 97703
PHONE 541-383-8066 FAX 541-383-3066

By initialing the space below, I specifically authorize the release of the following medical records, if such records exist

_____**ALL MEDICAL RECORDS** for the continuity of health care. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use of the highly confidential information may apply. I understand and agree that this highly confidential information will be disclosed if I place my initials in the applicable space.

_____HIV/AIDS related records ____Mental Health Information ____Drug/Alcohol diagnosis, treatment

_____Genetic Testing Information___Psychotherapy Notes

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: Creating health information about you to be disclosed to a third party; or For the purpose of research

Patient Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by West Bend Family Medicine based upon this authorization. To revoke this authorization, I must write a letter to West Bend Family Medicine. This information may be subject to re-disclosure and may no longer be protected by federal or state privacy laws. This Authorization expires 180 days from the date of this signed Authorization.

I have read this authorization and understand it.

_____

Patient Signature (or legal representative) _____

_____ _____

Printed name of Patient if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)