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

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

I hereby Authorize: **WEST BEND FAMILY MEDICINE**

633 NW York Dr. Ste. #110
Bend, OR 97703
Phone#: (541)383-8066 Fax#: (541)383-3066

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

◯ To **RECEIVE** a copy of the specific health information below regarding:

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

Patient Phone #: _____ **Patient Last 4 SSN: XXX-XX-**_____

Facility/Provider Name: _____

Phone #: _____ **Fax #:** _____

Mailing Address/Location: _____

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

Initial _____ ****ALL MEDICAL RECORDS (past 3 years) **** 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.

****INITALS REQUIRED (***even if you feel they may not apply, unless you do NOT want disclosure* _____ *Initials)*

Initial _____ ****HIV/AIDS related records** Initial _____ ****Mental Health Information** Initial _____ ****Drug/Alcohol diagnosis/treatment**

Initial _____ **** Genetic Testing Information** Initial _____ ****Psychotherapy Notes**

Initial _____ **Other Medical Records (Please Specify):** _____

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. I may not be able to revoke this authorization if its purpose were to obtain life insurance. 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:

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

Patient Signature *(or legally authorized individual)*: _____ **Date Signed:** _____

Name/Relationship if Signer is Not Patient: _____