Weeks Family Medicine

Authorization for Disclosure of Protected Health Information

Last Name:	First:	MI:	Date of birth:
Other Names used:	Patient address:		Phone:

By signing this form, I authorize the following record holder to disclose confidential information about me

SECTION A				
	Releasing records from:		**Specific information to be disclosed:**	**Mutual exchange: YES/NO**
	Street Address:			
	City:	**State**		
	Phone:	**Fax:**		
	If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information.			
	HIV/AIDS:	**Mental Health:**	**Genetic Testing:**	**Drug/Alcohol Treatment:**

SECTION B				
	Releasing records to:		**Purpose for disclosure:**	**Mutual exchange: YES/NO**
	Street Address:			
	City:	**State**		
	Phone:	**Fax:**		
	***This Authorization is valid for one year from the date of signing unless otherwise specified.** *I can cancel this authorization at any time. The cancellation will not affect any information about my care. I understand that state and federal law protect information about my care. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will.*			

SECTION C			
	Signature (patient or representative):	**Relationship to patient:**	**Date:**
	Signature of witness:	**Printed witness name:**	**Date:**
	Signature of sending staff:	**Printed staff name:**	**Fax/Mail date:**

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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 in order to be compliant with HIPAA.

- Medical records can be released to healthcare providers who are participating in your care. 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 can be used, or you can write a letter with all the appropriate information. Faxes are accepted for patient requests, if your signature can be validated. **NO emails or telephone/verbal requests can be made.**

- 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.

- 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 costs 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 (listed below).

- We reserve the right to waive this fee given certain circumstances.

Weeks Family Medicine is aware that HIPAA does not require written consent for all releases of medical information but chooses to implement this policy to assure the confidentiality and privacy of our patients.

The Omnibus Rule, effective 9/23/2013, "allows for the identification of labor costs for copying protected health information (PHI), whether in paper or electronic form, which can include a reasonable cost-based fee for time spent creating and copying the file". The laws for copying medical records vary 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 records are processed within 7 business days*

X-rays and other media: *Actual cost of reproduction*
Postage: *Actual cost of mailing*

2017 ORS 192.563 https://www.oregonlaws.org/ors/192.563