Weeks Family Medicine

Authorization for Disclosure of Protected Health Information - Receiving

Patient Name:	Date of Birth:

I authorize _____

(Receiving records from)

Facility Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

To disclose the following health information:

___ All records from date(s) _____ to _____

___ Records pertaining to _____.

Individual or entity authorized to receive my health information: *Weeks Family Medicine*

Purpose for which disclosure is to be made: _____

(Example: change of doctor, continuing care, moving, etc.)

By initialing the space(s) below, I am specifically authorizing the release of the following information:

_____ Medical records from alcohol and / or drug abuse treatment center(s).

_____ HIV (human immunodeficiency virus) test date(s) – NO RESULTS

_____ HIV (human immunodeficiency virus) test results

_____ Genetic testing results

** Note the HIV are one time releases and a new release must be signed for additional records to be released.
** Psychiatric (mental health) records require a separate release form per ORS 192.525

Restriction Requested: _____

* I understand that if the person(s) or entity (ies) that receive the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and is no longer protected by those regulations. Therefore, I release Weeks Family Medicine, its employees, and my physicians from all liability arising from this disclosure of my health information.
* I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.
* I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, make payment, or my eligibility for benefits.

FAX Authorization: I specifically give authorization to FAX my medical information (less than 20 pages). I understand the risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information. _____ (please initial here)

Signature: _____ Date:_____ Signature: _____

(Patient or Legal Representative) (Witness)

FOR OFFICE USE ONLY: FAX/MAIL DATE: _____ BY: _____

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