



Authorization for Disclosure of Protected Health Information - Sending

Patient Name: _____ Date of Birth: _____

I authorize to disclose the following health information:

- Physician Notes History and Physical Exam Lab Reports EKG
- Pathology Reports Emergency Room Reports Consultations Immunization Records
- Radiology Reports Discharge Summary Operative Reports

Individual or entity authorized to RECEIVE my health information: _____

Facility Address: _____ City: _____

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

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 redisclosed 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: _____