Grants Pass Clinic, L.L.P.

495 SW RAMSEY AVE
GRANTS PASS OR 97527

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

THIS INFORMATION MUST BE WRITTEN, DATED AND SIGNED BY THE PATIENT OR BY A PERSON AUTHORIZED BY LAW TO GIVE THIS AUTHORIZATION

PH 541-476-6644
FAX 541-472-5673

MRN_____

A. I _____ _____ _____
(Patient Name) *(Date of Birth)* *(Phone)*

authorize a copy of my Medical Records to be released:

TO: _____

Address: _____

_____

Phone: _____FAX: _____

FROM: _____

Address: _____

_____

Phone: _____ FAX: _____

Purpose of Disclosure: _____ _____

This authorization DISCONTINUES my care through Grants Pass Clinic. Yes_____ No_____

B. By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:
(MUST BE INITIALED. DO NOT CHECK-MARK.)

_____ Pertinent 3-yr Medical Records _____ Diagnostic Imaging _____ Laboratory Reports
_____ Physical Therapy Records _____ Pathology Reports
_____ Other _____

C. Records that include the information listed below are protected by additional laws related to the use and disclosure of information.

I understand and agree that this information will be disclosed if I place my initials in the space behind "Yes". Please be sure to initial YES or NO for each line.

Yes_____release OR No_____DO NOT release HIV/AIDS/ Sexually transmitted disease information
Yes_____release OR No_____DO NOT release Mental Health information
Yes_____release OR No_____DO NOT release Alcohol/chemical dependency diagnosis, treatment, referral info
Yes_____release OR No_____DO NOT release Genetic testing information
Yes_____release OR No_____DO NOT release information

NOTE: The information used or disclosed as directed by this authorization may be re-disclosed and no longer protected under federal law. However, federal law restricts re-disclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to re-disclosure.

D. I have read this authorization and understand it. Unless revoked, this authorization will expire 180 days from the date of signing.

Signature: _____ **Date:** _____
(Patient or person authorized by law)

Printed Name: _____

If signature above **is not the patient**, please describe authority to act on patient's behalf: _____

YOUR RIGHTS: You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment, payment or eligibility for benefits. You may inspect or obtain a copy of the health information that is requested and authorize its release. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use of disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Grants Pass Clinic Records Release Department, 495 SW Ramsey Ave, Grants Pass OR 97527 and state that you are revoking this authorization.

***** Although 30 days are allowed to process requests, we will make every effort to expedite the process*****