MRN ___________________

Grants Pass Clinic, L.L.P.
495 SW Ramsey Ave
Grants Pass, OR 97527
(541) 476-6644 Fax (541) 472-5673

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

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

Mailed______
Faxed _______
Date__________
Staff Initials________

A. I ______________________________________ ______________ ______________

Patient Name | Date of Birth | Phone

hereby authorize a copy of my Medical Records to be released:

TO: *Provider*_______________________________
Address _______________________________
____
Phone _________________________
Fax _________________________

FROM: *Provider* _______________________________
Address _______________________________
____
Phone _________________________
Fax _________________________

Purpose of Disclosure: Changing Provider/Clinic ____ Other____

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.)***

_______ Pertinent 3-yr Medical Records _______ Diagnostic imaging reports _______ Laboratory reports
_______ Physical therapy records _______ Pathology reports
_______ Specific Request/other ____

C. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the space behind "Yes".**

Yes_______release **OR** No________do not release HIV/AIDS information
Yes_______release **OR** No________do not release Mental health information
Yes_______release **OR** No________do not release Alcohol/chemical dependency diagnosis, treatment, or referral information
Yes_______release **OR** No________do not release Genetic testing information
Yes_______release **OR** No________ do not release Sexually transmitted disease information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services.

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 or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Grants Pass Clinic Records Release Dept., 495 SW Ramsey Ave., Grants Pass, OR 97527 and state you are revoking this authorization.

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

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 person's authority to act on patient's behalf (below):

____

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