

MRN _____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION



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

**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 _____	FROM: Provider _____
Address _____	Address _____
Phone _____	Phone _____
Fax _____	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****