Please use this form to request pertinent records from your provider(s) well in advance of your appointment.
Records must be received prior to your appointment.
It is your responsibility to request and provide records for your treatment.

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.

I authorize information to be released **FROM**

_____
Name of Facility

_____
PO Box/Street Address

_____
City, State, Zip

Please send my records **TO**

_____
Name of Facility

_____
PO Box/Street Address

_____
City, State, Zip

PURPOSE OF THIS RELEASE: □Medical Care □Transfer of Care □Relocating □Legal □Billing □Request of Individual

TYPE OF INFORMATION TO BE RELEASED: (please initial all that apply)

_____ All medical records (limited to last 2 years unless otherwise indicated

_____ Physician notes

_____ X-Ray reports

_____ Lab and/or pathology reports

_____ Hospital records/consultations

_____ Physical therapy records

_____ Work Comp injury records

_____ Other_____

Must be initialed to be included in other documents*

_____ HIV/AIDS – related records

_____ Mental Health Counseling &/or treatment information, including information regarding depression, anxiety and stress.

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment or referral information. (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of info is to be disclosed). If applicable, complete restriction box below.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of creating health information about you to be disclosed to a third party or for the purpose of research.
You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke you Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at Oregon Optimal Health, 1200 Executive Pkwy, Ste 360, Eugene, OR 97401, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.
This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

RESTRICTIONS – Initial & Complete if applicable:

_____ This authorization is limited to the following time period _____

_____ This authorization is limited to the following treatment: _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____
Patient name (Printed) DOB Phone Number

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Signature of patient or legally responsible person Relationship to patient Date

I specifically give authorization to FAX my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instruction for returning misdirected information. _____ (initial here to give permission to fax)