FAMILY HEALTH
ASSOCIATES

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, *[patient]*_____SS#_____ DOB_____ authorize *[name of provider]*_____ to use and/or disclose my health information as identified below to: *[Name of recipient/Doctor]*_____
*[Address and Fax # of recipient/Doctor]*_____
(We will not process this request unless given complete name, address and fax number.)

For the following purpose(s): *[describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]* _____.

By ***INITIALING*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

____Please send the **entire medical record** (*all information*) to the above named recipient.

Or just these items:

____All hospital records (including nursing records & progress notes)	____Clinician office chart notes	____Billing statements
____Transcribed hospital reports	____Dental records	____Diagnostic imaging reports
____Medical records needed for continuity of care	____Laboratory reports	____Pathology reports
____Other_____	____Emergency and urgent care records	____Most recent five-year history

*The following items must be ***INITIALED*** to be **EXCLUDED** in the use or disclosure of other health information:

____*HIV / AIDS related health information and/or records

____*Mental health information and/or records

____*Genetic testing information and/or records

____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

This authorization will remain in effect for one year from the date of signature unless a stop date is identified. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [insert applicable date or event of expiration]_____.

_____ _____ _____
Signature of Individual or Individual's Legal Representative | Date | Phone

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.) 9.27.17