Family Health Associates

RELEASE OF INFORMATION (ROI) CONSENT FORM
AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

SSN: _____ Phone#: _____

1. **Information requested from: _____ Phone#_____**

   Address: _____ Fax# _____

2. **Send information to: _____ Fax# _____**

   Address: _____

FHA will NOT accept paper charts. We accept fax or digital copy only.

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:

____**Send entire medical record** (**all information*) to the above named recipient
**For requests beyond most recent history, patient will be charged a reasonable copy/postage fee up to a maximum of $50.00).*

OR

____**Send most recent history** to the above named recipient
**Includes up to 2 years chart notes, 2 years progress notes and last 3 labs or 50 pages, whichever is greater as well as current medications list, allergy list, active problem list and immunization history.*

____Clinician office chart notes ____Billing statements ____Pathology reports
____Emergency and urgent care records ____Laboratory reports ____Diagnostic imaging reports
____Medical records needed for continuity of care ___Other_____

*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 redisclosed 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 number

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

FHA – Hermiston – 600 NW 11th St, Suite E-15, Hermiston, OR 97838 – Phone (541) 567-6434 – Fax (541) 429-6613
FHA – Umatilla – 1890 7th St, #8, Umatilla, OR 97882