CFM CORVALLIS FAMILY MEDICINE P.C. *Your family's health begins here.*

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient **Last** Name	Patient **First** Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? ☐ Yes ☐ No
Patient's Mailing Address		

Healthcare Provider to ☐ **Release** or ☐ **Receive** Information:

Name **Corvallis Family Medicine, P.C.**		
Address **2400 NW Kings Blvd**		
City **Corvallis**	State **OR**	Zip **97330**
Phone **541-757-2400**	Fax **541-752-0931**	

Person or Agency to ☐ **Receive** or ☐ **Release** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

For the purpose of: ☐ **request of the patient** ☐ **request of the recipient** ☐ **transfer care** ☐ **other**

By ***checking*** the box (s) below, I specifically authorize the release of the following medical records, if such records exist:

☐ Physician notes and records (limited to the most recent two (2) years of information and does not include other protected information)
☐ Laboratory reports
Please specify type and/or date range: _____
☐ Diagnostic imaging reports
Please specify type and/or date range: _____
☐ Other (Specify): _____

The following items **must be initialed** to be released:
_____ HIV-positive test results and HIV diagnosis
_____ Mental health information and/or records (Oregon only)
_____ Genetic testing information and/or records (Oregon only)
_____ Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on _____. Please allow up to 30 days for processing of routine record releases.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (If other than patient, proof of authority is required.) Relationship to Patient

****Oregon Medical Association rules state that patients 15 years and older must sign their own release for it to be valid****

IMPORTANT
PLEASE READ

Dear Patients: In order to process your records in a timely manner please read the following carefully!

Most recent two year history: Two years of medical records, counting back from your most recent office visit at our clinic. This includes all records, office notes, labs, diagnostic imaging, immunizations, etc.

Information that is protected by special HIPAA laws and requires your initials:

HIV information: If you were diagnosed or tested positive for this disease, please *initial* if you want this information included.

Mental health information: This includes depression, anxiety, ADHD, mood disorder, autism, or any other issue having to do with your mental health. This could be included in a chart note under Medical History as a prior diagnosis or as medication prescribed for one of these issues. Please *initial* if you want this information included.

Genetic testing information: These are gene tests used to test for genetic disorders, diagnosing vulnerabilities to inherited diseases, biochemical tests for the possible presence of genetic diseases, risk of developing genetic disorders and to find changes that are associated with inherited disorders. Please *initial* if you want this information included.

Drug/alcohol: Diagnosis, treatment or referral information (Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information.) Please *initial* if you want this information included.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE INITIALLING.

WE RESERVE THE RIGHT TO CHARGE FOR THE COST OF COPYING THE RECORDS.
(1) No more than $25 for copying 10 or fewer pages of written material and no more than 25 cents per page for each additional page; (2) Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual; and (3) Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual.

THANK YOU ☺ CORVALLIS FAMILY MEDICINE
2400 NW KINGS BLVD, CORVALLIS OR 97330
P: 541-757-2400 F: 541-752-0931