

FALL CREEK INTERNAL MEDICINE, LLP
Phone: 541-389-1118 Fax: 541-389-2662
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Print Patient Full Name _____ Date of Birth (mo/day/yr) _____ XXX-XX
SS# last 4 only _____

Street/POB _____ City _____ State _____ Zip Code _____ Phone Number _____

I hereby authorize _____ to release the following records:

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

- | | |
|-----------------------------------|--|
| _____ Clinical Office Notes | _____ Radiology Report |
| _____ Hospital Records | _____ Laboratory Reports |
| _____ Operative Reports | _____ Pathology Reports |
| _____ Last 5 years of all records | _____ Other/Specific Date Range (describe below) |

I also authorize release of information related to: "Specially Protected Information"

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 applicable space next to the type of information.

The following items must be INITIALED in the Appropriate Spaces

_____ ***HIV / AIDS related Health Information and/or records**

_____ ***Mental Health / Psychiatric Care Information and/or records**

_____ ***Genetic Testing Information and/or records**

_____ ***Drug / Alcohol Diagnosis, Treatment, and or Referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

Provider 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. The only circumstance when refusal to sign means you 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 disclosure.

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. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. I understand the information used or disclosed may be subject to disclosure by the person, class of persons or facility receiving it, and would no longer be protected by federal regulations

To revoke this authorization, please send a written statement to: **Fall Creek Internal Medicine at 2160 NE Williamson Ct Bend, OR 97701** and state you are revoking this authorization.

I Authorize Information to be RELEASED to: _____
Name, phone, address of recipient or class of recipients

For the Purpose of: _____
Describe each purpose of disclosure or indicate that disclosure is at request of individual

I have read this authorization and I understand and accept the statements contained in this authorization, I also understand unless revoked early, this authorization will expire one year from the date of original signing.

Signature of PATIENT or PERSONAL REPRESENTATIVE _____ DATE _____