

West Hills Healthcare Clinic
2163 NW 2nd St., McMinnville, OR 97128
Phone (503) 472-4197 Fax (503) 434-2886

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth: ____/____/____

I authorize West Hills Healthcare Clinic to release my health information that I have identified below to:

Name _____ Fax _____

Address _____ City _____ State _____ Zip _____ Phone _____

for the purpose(s) of: _____ Expires in 180 days or: _____

The spaces below MUST BE INITIALED to specifically authorize the release of the following health information and/or records, if such information and/or records exist:

<input type="checkbox"/> ALL RECORDS	<input type="checkbox"/> Clinician office chart notes
<input type="checkbox"/> Transcribed hospital reports	<input type="checkbox"/> Dental Records
<input type="checkbox"/> Medical records needed for continuity of care	<input type="checkbox"/> Laboratory reports
<input type="checkbox"/> Most recent five-year history	<input type="checkbox"/> Pathology reports
<input type="checkbox"/> Emergency and urgent care records	<input type="checkbox"/> Diagnostic imaging reports
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Billing statements

***Each of the following items MUST BE INITIALED to be included 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 required a description how much and what kind of information is to be disclosed: _____)

* Psychotherapy notes (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with another authorization).

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to West Hills Healthcare Clinic.

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 copy 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 information under the applicable state or federal law 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.

Signature of Individual

Print Name

Date

Signature of Legal Representative

Description of Legal Authority