Authorization to Disclose Protected Health Information

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Section 1

Patient Name:_____Date of Birth: ___/___/____

Previous Name: _____SSN: _____

Section 2

Purpose of this disclosure (check all that apply)

- ☐ Transfer of patient care
- ☐ Legal
- ☐ Coordination of care
- ☐ Prenatal Care
- ☐ At Request of Patient
- ☐ Eligibility Determination

Section 3

I request and authorize the individual/ Clinic/ Provider listed below to release/ receive a copy of my medical record:

- ☐ I want to send my records **from** Dr. Schulz to:
- ☐ I want to send my records **to** Dr. Schulz from:

Section 4

Name of Provider/ Clinic/ Provider:_____

Phone: _____Fax:_____

Address:_____

Section 5

This authorization gives permission to release the following records:

- ☐ Entire Medical Record
- ☐ Imaging
- ☐ Immunization/ Lab Records
- ☐ Other (describe)_____

I understand that certain information cannot be released without specific permission as required by State/ Federal law. By Initialing, I authorize the release of the following protected or sensitive information.

_____Drug/ Alcohol/ Treatment/ Referral Information _____STD/AIDS/HIV testing

_____Mental Health Diagnosis/ Treatment _____Genetic Testing

Signature: _____ **Today's Date:** _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Dr. Schulz and state that you are revoking this authorization. Unless revoked earlier, this consent will expire upon:_____ or one year from signed date if left blank. To the recipients of protected health information: the information disclosed to you by his authorization is protected by state law (ORS 179.505, 192.516) and federal regulations (43 CFR Part 2, 45 CFR 160-164). You are instructed that you may not further disclose this information without the express written consent of a person to whom it information pertains. A general authorization for release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.