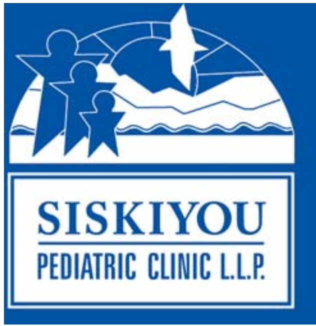

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700 S.W. Ramsey, Suite 204, Grants Pass, OR 97527
Phone: 541-955-5683 (love) • **Fax:** 541-955-0983

Healthcare for Infants, Children & Adolescents

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: ____ **DATE OF BIRTH:** ____________________

I authorize: ____
(NAME AND ADDRESS OF INDIVIDUAL/ENTITY **RELEASING** INFORMATION)
to use and disclose a copy of the specific health information described below to:

____
(NAME AND ADDRESS OF INDIVIDUAL/ENTITY **RECEIVING** INFORMATION)

for the purpose(s) of: ____
(SPECIFICALLY DESCRIBE EACH PURPOSE FOR DISCLOSURE)

By **initialing** the spaces below, I specifically authorize the release of the following medical records, of such records exist. **Please initial for release of records (do not check spaces).**

____ All pertinent medical records
____ Laboratory Reports/Pathology Reports
____ Diagnostic Imaging Reports
____ Physical Therapy records
____ Other (specify) ___________________
____ Most recent three (3) year history
____ This authorization is limited to the following treatment: ____
____ This Authorization is limited to the following time period: ____
____ This Authorization is limited to Worker's Comp claims for injuries of: _________________________________

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.

____ HIV/AIDS information
____ Mental health information
____ Genetic testing information
____ Drug/Alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal restricts re-disclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to re-disclosure.

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 that 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.

To revoke this authorization, please send a written statement to our Medical Records Department at Siskiyou Pediatric Clinic, 700 SW Ramsey Ave., Ste 204, Grants Pass, OR 97527 and state that you are revoking this authorization.

____ ______________________ ______________
Signature of patient or legally responsible person∗ Relationship to patient Date

∗In the event a legal representative other than parents of a minor child signs this Authorization, documentation of legal authority must be attached (i.e. Healthcare Power of Attorney or Court appointed Health Care Representative.)

7.1.16