REEDSPORT MEDICAL CLINIC

385 Ranch Road · Reedsport, OR 97467

Primary Care Provider Ph: (541)271-2119/ Fax: (541)271-9338

Surgeon and Orthopedic Ph: (541)271-2119/ Fax: (541)271-6362

Representative Authorization

I authorize Reedsport Medical Clinic / Lower Umpqua Hospital District to share my personal information regarding my health care needs with:

1. _____

2. _____

3. _____

4. _____

Their Address is:

1. _____

2. _____

3. _____

4. _____

Their Telephone number is:

1. _____

2. _____

3. _____

4. _____

Patient Signature: _____ Date:_____

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS:
This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize_____

_____

(name of doctor, facility, phone number and address) to release a copy of the medical information for:

Patient Name: _____DOB:_____

To:_____

_____

(name of person or doctor, facility, phone number and address of recipient)

The information will be used on my behalf for the purpose(s):_____

*Please note if you are changing primary care doctors and no longer plan to be seen at this clinic

***By initialing spaces below**, I specifically authorize the release of the following medical records, if such records exist*

_____All clinic records (including progress notes, diagnostic testing, and hospital reports if available)

Specify amount of years _____ __ Operative/Procedure reports _____Transcribed hospital reports

_____Clinical office visit notes only __ All other diagnostic testing ____All Cardiac Testing / EKG

_____Laboratory/Pathology reports _____Billing Statements

_____Radiology reports _____**HIV/AIDS – related records*

_____***Drug/alcohol diagnosis, treatment or referral information* _____**Mental health information*

_____**Genetic testing information*

***MUST BE INITIALED TO BE INCLUDED IN OTHER DOCUMENTS*

****Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of information is disclosed.***

_____This authorization is limited to the following treatment:_____

_____This authorization is limited to this ***specific*** record(s) only_____

_____This authorization is limited to a workers compensation claim for injury of _____ date _____

I understand that the protected health information disclosed may be subject to re-disclosure by the party receiving the information and may no longer be protected. ***This authorization may be revoked at any time.*** The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, ***this consent will expire 180 days from the date of signing*** or shall remain in effect for the period reasonable needed to complete the request.

By initialing,

_____ _____ _____ **I consent for**

(Date) **(Signature of Patient)** **records to be faxed**

_____ _____

(Date) **(Signature of Person Authorized by Law)**

_____ _____

(Date) **(Signature of Witness)**

IF SENDING MORE THAN 50 PAGES- PLEASE MAIL