

MRN: _____	ID CHECKED: _____	BY: _____
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AUTHORIZATION TO DISCLOSE or OBTAIN 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 (*facility*) _____ to release a copy of the medical information for (*name of patient*) _____
 (*date of birth*) _____ to (*name and address of recipient*) _____

The information will be used on my behalf for the following purpose:

Continuity of Care, Personal Records, Insurance, Other _____

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

PLEASE INITIAL

- | | |
|---|---|
| <p>_____ All hospital records
 (including nursing notes/progress notes)</p> <p>_____ Most recent 2 year history
 (dictations, labs, x-rays)</p> <p>_____ Physical Therapy records</p> <p>_____ Laboratory reports</p> <p>_____ Operative reports and/or
 Path reports</p> <p>_____ Other: _____</p> | <p>_____ Progress Notes/Medication</p> <p>_____ Records for continuity of care
 (dictations, labs, x-rays)</p> <p>_____ Emergency care records</p> <p>_____ Billing statements</p> <p>_____ Radiology reports</p> |
|---|---|

PLEASE INITIAL

SENSITIVE RECORDS

- _____ Mental Health Records
- _____ Drug/Alcohol records
- _____ HIV/AIDS related records
- _____ Genetic Testing information

I ask that this authorization expire on (date) _____ or on (an event. If no date or event is specified, this authorization will be in effect for a period of six (6) months from the date signed below. Upon conclusion of that time period (*unless earlier revoked by me in writing*), this authorization is automatically revoked. I understand that I may revoke this authorization at any time by notifying Lower Umpqua Hospital in writing except to the extent that action has been taken in reliance on this authorization.

This authorization is limited to:

Following date's/treatment: _____

Workers compensation claim for injuries of _____ (date)

 (date) (Signature of patient) or (guardian/person authorized by law)

 (date) Witness - staff at facility

INSTRUCTIONS FOR COMPLETING A RELEASE OF INFORMATION FORM

If you are filling out the release of information form online, or are mailing the form to us, please read over the instructions. We follow the HIPAA guidelines when handling requests so each section is important to complete.

- In the box at the top of the page is the section for us to enter your MR# and I.D. information. We are required to check I.D. of the person requesting the records. If you are sending the release to our facility please attach a copy of your driver's license or other I.D. with photo and signature. If this is not done we cannot make and send the copies requested. This must be the I.D. of the patient, or the legally authorized party.
- The first section is self explanatory for name of facility releasing information, patient name, date of birth, who will receive the records. If possible, please include the address and phone number.
- The second section is to mark the purpose of the records request.
- The third section of the form asks that you initial by the copies you are requesting. A check mark in these areas is not the same thing. *Please initial.*
The items in the box marked "Sensitive Records" must be initialed for that information to be released.
- The fourth section is so that a date or event that you enter can be the time frame in which the request is active, and then will expire. If not marked then this authorization is good for a period of 6 months from the date of the signature.
- The fifth and final section requires the signature of the individual whose records are being requested. If that person is not available or unable to sign, the person picking up the records must have a "Power of Attorney for Healthcare" and bring their I.D.
If that individual wanting records is a minor, then a parent or guardian needs to sign the bottom of the form where noted.
If the person is deceased and a party requests records, they must be a close relative such as parent/spouse and be able to prove they have executorship over the deceased's belongings, bring a death certificate and proof of their identity.