LOWER UMPQUA HOSPITAL DISTRICT ~ 600 Ranch Road, Reedsport, OR 97467
P: (541) 271-2171 ~ F: (541) 271-6322 (Medical Records) or (541) 271- 6363 (Emergency Room) as requested.
DUNES FAMILY HEALTH CARE ~620 Ranch Road, Reedsport, OR 97467
P: 541-271-2163 F: 541-271-4058
REEDSPORT MEDICAL CLINIC ~385 Ranch Road, Reedsport, OR 97467
P: 541-271-2119 F: 541-271-9338

MRN:_____ ***ID CHECKED:***_____ ***BY:***_____

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

_____ All records (including nursing notes/progress notes)

_____Most recent 2 year history (dictations, labs, x-rays)

_____Physical Therapy records

_____Laboratory reports

_____Operative reports and/or Path reports

_____Progress Notes/Medication

_____ Records for continuity of care (dictations, labs, x-rays)

_____ Emergency care records

_____ Billing statements

_____ Radiology reports

PLEASE INITIAL

SENSITIVE RECORDS

____ Mental Health Records

____ Drug/Alcohol records

____ HIV/AIDS related records

____Genetic Testing information

_____Other: _____

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. I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that 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. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Lower Umpqua Hospital District or myself. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions or genetic information.

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***

revised on: 06/2020

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.