R	EEDSPORT MEDICA P:	AL CLINIC ~385 R 541-271-2119 FAX		•	sport, OR 97467
M	RN:	ID CHECKED:		BY:	
Nhia arahari		TO DISCLOSE or			
	zation must be writt y law to give author		nea i	y the patie	nt or by a person
authorize (<u>f</u>	acility)				to release a copy of
he medical i	nformation for <u>(name o</u>	of patient)			
date of birth)	t	to (name and addres s	s of re	cipient)	
	on will be used on my of Care	6	-		
By initialin f such record		specifically author	ize th	e release of t	the following medical record
	FIAL cords (including nursing rogress notes)	Progress N	otes/	Medication	PLEASE INITIAL <u>SENSITIVE RECORDS</u>
	recent 2-year	Records for		e	Mental Health Records
	Y (dictations, labs, x-rays)	care (dictatio	ns, labs	, x-rays)	Drug/Alcohol records
Physic	cal Therapy records	Emergency	care	records	HIV/AIDS related records
	10	Billing stat	emen	ts	Genetic Testing informatio
	atory reports	Radiology :	report	S	
	tive reports and/or reports	Other:			
f no date or ev igned below. Us s automaticall Jmpqua Hospi authorization. not affect my a hat the health he authorizati pursuant to th lower Umpqua lisclosure of H nformation.	Jpon conclusion of that y revoked. I understand tal District in writing ex I understand I do not h bility to receive healthc care services are solely on is necessary to make is authorization, it may	athorization will be in t time period (<i>unless</i> d I may revoke this a xcept to the extent th ave to sign this auth eare services or reimb y for the purpose of p e that disclosure. I u be re-disclosed by th yself. However, I also nental health informa	effect earlier uthori at act orizat oursen rovidi nders ne rec o unde ation,	for a period of revoked by m zation at any ion has been ion. My refusa- nent for servic ng health info cand once the pient without erstand federa	of six (6) months from the date <i>ne in writing</i>), this authorizatio time by notifying Lower taken in reliance on this al to sign this authorization will ces except in the circumstance ormation to someone else and information is disclosed t the knowledge or consent of al and state law may restrict re conditions or genetic
Workers co					
Date	Signature of patient	t	or	Guardian/	Person authorized by law
Date	Witness Signature o	f staff at facility			

84400-004REV0620

INSTRUCTIONS FOR COMPLETING A RELEASE OF INFORMATION FORM

If you are filling out the Release of Information form online or 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 legal authorized representative.
- The first section is name of facility releasing the information, patient name, date of birth, and 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 for **<u>initials</u>** for the content/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" <u>must</u> also be initialed for the information to be released.

- The fourth section is for a date or event you enter is the time frame in which the request is active, and then will expire. If not marked, the 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 <u>parent/spouse</u> and be able to prove they have executorship over the deceased's belongings, bring a death certificate and proof of their identity.