Integrative Family Medicine of Bend

Authorization For Release of Medical Records

Print Patient Full Name | Date of Birth | SS# last 4 only

Address | City | State | Zipcode

I hereby authorize the following to release my medical records:

Name | Phone Number | Fax

By CHECKING the spaces below, I specifically authorize the use of the following, health information and/or records, if such information and records exist:

- ☐ Clinical Office Notes
- ☐ Operative Reports
- ☐ Laboratory Reports
- ☐ Last 5 years of all records
- ☐ Hospital Records
- ☐ Radiology Report
- ☐ Pathology Reports
- ☐ Other/Specific Date Range (describe)

I also authorize release of information related to: “Specially Protected Information”

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.

The following items must be INITIALED in the Appropriate Spaces

☐ *HIV / AIDS related Health Information and/or records

☐ *Mental Health / Psychiatric Care Information and/or records

☐ *Genetic Testing Information and/or records

☐ *Drug / Alcohol Diagnosis, Treatment, and or Referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

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 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. I understand the information used or disclosed may be subject to disclosure by the person, class of persons or facility receiving it, and would no longer be protected by federal regulation.

To revoke this authorization, please send a written statement to: Integrative Family Medicine of Bend, 2450 NE Mary Rose Place, Suite 220, Bend, OR 97701 and state you are revoking this authorization.

I authorize information to be RELEASED to:

Name: Phone Number Fax

Address of Recipients City State Zipcode

For the Purpose of:

I have read this authorization and I understand and accept the statements contained in this authorization, I also understand unless revoked early, this authorization will expire one year **from the date of original signing**.

Signature of PATIENT or PERSONAL REPRESENTATIVE Date