FALL CREEK INTERNAL MEDICINE, LLP

Phone: 541-389-1118 Fax: 541-389-2662 Email: clinicadmin@fallcreekmd.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____________________________________ _____________________ **XXX-XX**______________
Print Patient Full Name Date of Birth (mo/day/yr) SS# last 4 only

____ ____________________
Street/POB City State Zip Code Phone Number

I hereby authorize ____to release the following records:

By INITIALING 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
_______ Hospital Records
_______ Operative Reports
_______ Last 5 years of all records
_______ Radiology Report
_______ Laboratory Reports
_______ Pathology Reports
_______ Other/Specific Date Range (describe below)
____

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 regulations

To revoke this authorization, please send a written statement to: **Fall Creek Internal Medicine** at **2160 NE Williamson Ct Bend, OR 97701** and state you are revoking this authorization.

I Authorize Information to be RELEASED to: ____
Name, phone, address of recipient or class of recipients

____

For the Purpose of: _____**TRANSFER OF CARE** _____**PERSONAL** ____**INSURANCE** ____**CONTINUITY OF CARE**

_____**ATTORNEY** _____**OTHER(please explain)**______________________________________
Describe each purpose of disclosure or indicate that disclosure is at request of individual

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**