

Authorization for Release of Health Information

Patient:

Last First Middle Date of Birth

I specifically authorize the release of the following records if such records exist:

History & Physical Chart Notes

Labs Immunizations

Food/Drug Allergies

Medications Diagnoses Mammogram Pap Smear Colonoscopy

Diagnostic Tests Operative Reports Radiology Consultation Reports Pathology Reports

 Dental Treatment Plans Dental X-Rays Dental Consult Notes

From: Deschutes Rim Health Clinic Telephone No: 541-395-2911

Address: 1605 George Jackson Rd Maupin. OR 97037 Fax No: 541-395-2912

To:

Name of Medical Office or Provider

City State Zip Code Telephone Fax

 For the purpose of**: Transferring care**

If the records contain any information of the type listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I initial in the space next to the information:

HIV/AIDS: \_\_\_\_\_\_\_\_\_Mental Health:

Genetic Testing \_\_\_\_\_\_\_\_

Alcohol/drug diagnoses, treatment, referral**: \_**

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law. Unless revoked earlier, this authorization shall remain in effect for 1 year of signing this authorization. I understand I can revoke this authorization at any time by sending a letter to Deschutes Rim Health Clinic. The cancellation will not affect any information that was already disclosed. Deschutes Rim Health Clinic cannot condition treatment or eligibility of benefits on whether the authorization is signed.

Patient's Signature Date

Other Authorized Person (print name) Relationship to

Authorized Person Signature

Date