DESCHUTES RIM
HEALTH CLINIC

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	Medications	Diagnostic Tests
Chart Notes	Diagnoses	Operative Reports
Labs	Mammogram	Radiology
Immunizations	Pap Smear	Consultation Reports
Food/Drug Allergies	Colonoscopy	Pathology Reports
Dental Treatment Plans	Dental X-Rays	

From: _____
Name of Medical Office or Provider

_____
City State Zip Code Telephone Fax

To: Deschutes Rim Health Clinic, PO Box 219, Maupin, OR 97037
Fax: 541-395-2912
Email: Clinicmanager@deschutesrimhealthclinic.org

For the purpose of: __Continuation of Medical Care__ For the Date(s):__All dates_____

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 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 after 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 Patient

_____ _____
Authorized Person Signature Date

Revised 10/2022