531 SE Clay Street, Dallas, OR 97338
Phone (971) 612-6100 / Fax (971) 612-6101

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, *[patient name]*____SS#____________________ DOB______________

authorize *[name of provider]*____ at *[address,fax,phone]*

____

to use and/or disclose my health information as identified below to **Dallas Family Care** for the following purpose: *[describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]*____.

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

____Please send the entire medical record (*all information*) to the above named recipient.
____All hospital records including nursing records & progress notes
____Transcribed hospital reports
____Medical records needed for continuity of care
____Most recent five-year history
____Emergency and urgent care records
____Other____
____Clinician office chart notes
____Dental records
____Laboratory reports
____Pathology reports
____Diagnostic imaging reports
____Billing statements

*The following items must be ***INITIALED*** to be included in the use or disclosure of other health information:

____*HIV / AIDS related health information and/or records

____*Mental health information and/or records

____*Genetic testing information and/or records

____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

This authorization will remain in effect for one year from the date of signature unless a stop date is identified. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [insert applicable date or event of expiration]____________________________________.

____ ____________________________
Signature of Individual or Individual's Legal Representative Date

____ ____________________________________
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual