Thurston
Medical Clinic

A home for your whole family

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Authorization of Disclosure of Protected Health Information

FOR FORM TO BE VALID, ALL SECTIONS MUST BE COMPLETED

Patient Name: _____ **Date of Birth:** _____ **Patient Phone#**: _____

I authorize the release of my medical information □ To / □ From **Thurston Medical Clinic.**

□ To / □ From (physician, office, or person):_____

Address: _____

Phone: _____ Fax#_____

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:

____**Send entire medical record** (**all information*)

**For requests beyond most recent history, patient will be charged a reasonable copy/postage fee up to a maximum of $50.00).*

OR

____**Send most recent history at *no charge*** to the above named recipient

**Includes up to 2 years chart notes, 2 years progress notes and last 3 labs or 50 pages, whichever is greater as well as current medications list, allergy list, active problem list and immunization history, last colonoscopy, DEXA, mammogram, diabetic eye exam, if applicable.*

____**Other**_____

I understand that the purpose of this release is for on-going medical care. The recipient of these records cannot transfer them to another party without consent from me or an authorized representative. This authorization will remain in effect of or 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. I understand that medical records may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, mental health concerns, or other sensitive information.**
I agree to the release of these records and have read all of this release. Any questions or concerns of mine have been answered.

_____ _____

Signature of Patient or Authorized Representative Date

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.

I further authorize that all psychiatric, drug, alcohol, Acquired Immunodeficiency Syndrome (AIDS) or HIV/HTLV test results/records be released to the above. In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the PURPOSE of HIV/HTLV test results/records. The purpose of release for HIV/AIDS test result/record is for: _____.
HIV test results may be released from: _____ to _____.

_____ _____

Signature of Individual or Individual's Legal Representative Date

_____ _____

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