Mason Harrison, FNP-C

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

Patient name _____ Date of birth _____

Authorization

I authorize _____ Fax number _____
(Name and address of individual/entity releasing information)

to use and disclose a copy of the specific health information described below to: For the purpose of:

River Rock Family Practice, PC. Fax (541) 226-9846 ***Transfer of care***

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist: Please **initial** for release of records (**do not *check* spaces**)

_____ ***Complete medical record***
_____ Laboratory reports/pathology reports
_____ Diagnostic imaging reports
_____ Most recent three (3) year history
_____ Physical therapy records
_____ Other (specify)_____
_____
_____
_____ This authorization is limited to the following treatment: _____
_____ This authorization is limited to the following time period: _____
_____ This authorization is limited to worker's comp claims for injuries of: _____

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.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Sexually transmitted disease information
_____ Mental health information
_____ Sexually transmitted disease information
_____ Alcohol/chemical dependency diagnosis, treatment or referral info.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

Patient information

You do not need to sign this authorization. Refusal to sign 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information) and state you are revoking this authorization.

This authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Signature

I have read this authorization and I understand it.

_____ _____
(Signature of individual or personal representative) *(Date)*

Description of personal representative's authority

_____