To Release Records Out of Our Clinic

Authorization for Willamette Valley Orthopedic & Sports Medicine To Use or Disclose My Health Care Information

REQUEST TO RELEASE INFORMATION

PATIENT IDENTIFICATION

Name: ______________________________ Date of Birth: __________________

Address: ____

____

Social Security #: ____________________Telephone: ___________________

DATES OF TREATMENT TO BE RELEASED

From (date): ___________________________

To (date): ______________________________

RECIPIENT INFORMATION

Name: ____

Address: ____

____

Telephone: __________________________ Fax: __________________________

PURPOSE OF REQUEST

☐ Treatment or consultation

☐ At the request of the patient

☐ Billing or claims payment

☐ Other: ______________________________

TYPE OF INFORMATION TO BE RELEASED

☐ Chart notes
☐ Procedure report
☐ Immunization records
☐ Prescription /Medication records
☐ History & Physical exam
☐ Consultation reports
☐ Laboratory test results
☐ Radiology reports

Other: ____

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer unless revoked, this authorization will expire in 180 days or on the following date/event: ___________.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. ☐ **YES** ☐ **NO_____Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ☐ **YES** ☐ **NO ___ Initials**

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that Willamette Psychiatry may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize Willamette Psychiatry to use and disclose the protected health information specified above.

Signature: ____Date: ________________________________

Relationship if not the patient:____

Identity of requester verified by whom: __________________
______ Photo ID
______ Matching signatures
______ Other: _____________________________________

Identity of recipient verified by whom: __________________
________ Photo ID
________ Matching signatures
________ Other: ______________________________

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