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 Moro, OR 97039
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Patient Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

All Previous Names: _____

I authorize Sherman County Medical Clinic to do the following: Provide Information to:
 Receive Information from:

 Facility /Person Phone Number

 Street Address City/ State/ Zip Code

❖ The information will be used on my behalf for the following purpose(s): _____

<p>Information to be released:</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> History and Physical Exam</p> <p><input type="checkbox"/> Laboratory Reports</p> <p><input type="checkbox"/> Diagnostic Imaging Reports</p> <p><input type="checkbox"/> Emergency Department Reports</p> <p><input type="checkbox"/> Medications</p> <p><input type="checkbox"/> Pathology Reports</p> <p><input type="checkbox"/> Medical Out-Patient Clinic Records</p> <p><input type="checkbox"/> Other: _____</p> <p>Treatment Dates: _____</p>	<p>By <i>initialing</i> in the spaces below, I authorize release of the following information:</p> <p>_____ HIV/ AIDS related information</p> <p>_____ Mental Health information</p> <p>_____ Drug/Alcohol diagnosis, treatment, or referral information</p> <p>_____ Genetic testing information</p> <p>Time Period: _____</p>
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- I understand that this authorization will automatically expire in 180 days from the date of my signature or on (specify date) _____
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Sherman County Medical Clinic, 110 Main Street, PO Box 186, Moro, Oregon 97039. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and not longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, treatment or referral information.
- I understand that I need not sign this form to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits.
- I understand that I will be given a copy of this authorization form, after signing.
- I have been advised there may be a fee assessed for providing this information. _____ (initials)

 Signature of Patient

 Date

 Signature of Personal Representative (if necessary)

 Indicate relationship to Patient