Southern Oregon Neuropsychological Clinic, LLC
837 Alder Creek Dr.
Medford, OR 97504
Phone 541-608-3878 Fax 541-608-3880

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

THIS IS TO AUTHORIZE RELEASE OF MEDICAL INFORMATION REGARDING

Patient_____Date of Birth_____

I authorize Southern Oregon Neuropsychological Clinic to share information with:_____

_____

FOR:

_____Release of information from the person or agency named above to Southern Oregon Neuropsychological Clinic.

_____Release of information from Southern Oregon Neuropsychological Clinic to the person or agency listed above.

PURPOSE OF RELEASE:_____

PLEASE CHECK AS APPROPRIATE:

_____Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

_____Disclose my complete health record except for the following information:

- _____Mental health records
- _____Communicable diseases including, but not limited to, HIV and AIDS
- _____Alcohol/substance abuse treatment records
- _____Other (specify)_____

This authorization to share my health information is valid for one year after the date of my signature.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not permit me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive. I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to Southern Oregon Neuropsychological Clinic at the address listed above. I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

Date_____ Signature_____

Printed Name_____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent/legal guardian/healthcare agent, please complete the following information:

Printed name of person completing this form: _____

Signature and relationship of person completing this form:_____

Parent/Guardian/Health Care Representative