Health Information Management

Phone 503-815-2395 Fax 503-815-2485

Patient Name _____ **Phone Number** (____) _____- _____

Date of Birth _____/_____/_____ **Medical Record #** _____-_____-_____

Address _____

City **State** **Zip**

Purpose for Information Release: ❑Continuing care ❑ Personal copy ❑ Other_____
❑ Patient will pick up ❑ Please mail ❑ Please fax

***Note:** Records exceeding 50 pages may be placed on CD. Smaller records available on CD by request.

Release information FROM: ❑ Tillamook Regional Medical Center (Hospital) ❑ Tillamook Medical Group (Clinics)
(Check all that apply) ❑ Tillamook Medical Associates ***(Prior to March 2009)*** ❑ Bay Ocean Medical ***(Prior to February 2010)***
❑ Bayshore Medicine ***(Prior to March 2013)***

Please RELEASE information FROM other:

_____
Name

_____
Street Address

_____
City/State/Zip

Please RELEASE my medical information TO:

_____
Name

_____
Street Address (or specified fax number)

_____
City/State/Zip

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS

❑ Date(s) of Service _____

❑ Specific Request _____

_____

Records of information to be included in the use/or disclosure to a third party, the requestor must initial the following:

_____ Mental Health Information _____ *HIV/AIDS related information and/or records

_____ Genetic Testing Information _____**Drug/Alcohol diagnostics, treatment or referral information

** Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.
* This information may not be re-disclosed without the specific authorization of the individual, except where authorized by law.

Restrictions: I understand the information released may be subject to re-disclosure by the recipient and may no longer be protected.
Rights: I understand I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. This authorization will expire on ___/___/___, or one year from date of signature if not otherwise specified.

*****BY LAW, WE HAVE UP TO 30 DAYS TO COMPLETE YOUR REQUEST FOR RECORDS. WE WILL CONTACT YOU AS SOON AS YOUR RECORDS ARE AVAILABLE*****

Signature _____ Date & Time _____
Patient/Legal Representative
If signed by other than patient, indicate relationship: _____
Pick up Initial_____ Date & Time_____

[Patient Label]

❑ Patient unable to sign, verbal authorization given (two witnesses required)

Staff Witness Signature	Date	Time
Staff Witness Signature	Date	Time

FOR OFFICE USE ONLY

❑ Copy of identity if individual and/or legal representative obtained/filed
❑ Patient personally known _____ Staff Initials

Notes_____

_____

_____Clerk Initials_____

REVOCATION OF AUTHORIZATION

In accordance with provisions of the Notice of Privacy Practices, I hereby revoke the:

❑ Above Authorization

❑ Authorization releasing information to _____

❑ Authorization Dated_____

_____

Signature (Patient/Legal Representative) Date Time

If signed by other than patient, indicate relationship _____

FOR OFFICE USE ONLY

Date Revocation Received _____

Medical Record Number _____ Clerk Initials _____

EXCEPTIONS

The exceptions noted in the Rights section one page 1 of this form include:

a) Authorization for research
b) Authorization for health plan enrollment
c) Authorization solely for the purpose of creating protected health information for a third party