Redmond Medical Clinic
Care | Relationships | Education

1245 NW 4th Street, Suite 201 | Redmond, OR 97756 | P (541) 323-4545 | F (541) 323-4546

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION: I authorize _____
(NAME OF INDIVIDUAL / ENTITY DISCLOSING INFORMATION)

To use and disclose the specific health information described below regarding:

_____ _____
(NAME OF INDIVIDUAL) (DATE OF BIRTH)

Consisting of:_____
(DESCRIBE INFORMATION TO BE USED / DISCLOSED)

To: _____
(NAME AND ADDRESS OF RECIPIENT OR RECIPIENTS)

For the purpose of: _____
(DESCRIBE EACH PURPOSE FOR DISCLOSURE)

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/ STI information
_____ Mental health information
_____ Genetic testing information
_____ Drugs/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no 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, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to disclosure

PATIENT INFORMATION:
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances 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 our HIPAA Compliance Officer at 1245 NW 4th Street, STE 201, Redmond OR 97756 and state you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it.
Unless revoked, this authorization expires: **One year from date of authorization origination.**

By: _____ Date: _____
(Individual or personal representative)

Description of personal representative's authority:

_____

I specifically give authorization to fax my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected Information.

Initials:_____