PRAXIS HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Phone#_____

REASON: ☐ Personal ☐ Medical Care ☐ Benefits ☐ Litigation ☐ Workman's Comp ☐ Permanent Transfer ☐ Other: _____

I AUTHORIZE INFORMATION RELEASE *FROM*:

_____
Name of Facility or Provider

_____
Address

_____
City, State, Zip

_____
Phone Fax

INFORMATION TO BE RELEASED *TO*:

Pendleton Family Medicine
Name of Facility, Provider or Individual

2450 SW Perkins Ave
Address

Pendleton, OR 97801
City, State, Zip

(541) 276-1700 **(541) 276-6327**
Phone Fax

Type of Information to be Released – Please check appropriate box(s)

☐ **Specific Information Only Please**

☐ Chart Notes ☐ Immunization Records ☐ Other: _____
☐ Laboratory Results ☐ Medications Records ☐ Mammogram
☐ Diagnostic Images/Reports ☐ Physical Therapy ☐ Colorectal Cancer Screening (Colonoscopy)

☐ **(For Desert Orthopedics ONLY) on disc $10 X-Ray $15 MRI $15 Both MRI/X-Ray**

☐ **Most Recent Visit** ☐ **Medical records from _____ to _____** ☐ **Last 2 years only** - includes 2 years chart /progress notes and last 3 labs or 50 pages, whichever is greater, plus current medications, allergies, active problem list and vaccine history.

Note: If no checkbox is selected, last 2 years will be sent - **COPY/POSTAGE FEES UP TO $50 MAY APPLY FOR MORE THAN 2 YEARS.**

Protected or Sensitive Information

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 information
Initials

_____ Mental health/Psychotherapy notes/Neuropsychological Results – *staff will also obtain documented provider approval in chart before release*
Initials

_____ Genetic testing information
Initials

_____ Drug/Alcohol diagnosis, treatment, or referral information
Initials

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.
- I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.
- This authorization will remain in effect for *one year* from the date of signature unless a stop date is identified.
- I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [insert applicable date or event of expiration]_____.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Patient's Name or Name of Patient's Legal Representative (if applicable) Relationship to Patient