McKenzie Medical Group

Release of Information

Request From Other Agency

All portions of this form must be completed to constitute a valid authorization for release of information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name: _____ Date of birth: ____/____/_____

Address: _____City_____State:_____ Zip: _____ Phone:_____

I authorize: Agency or Individual authorized to release my health information: _____

Agency phone: _____ **Agency fax:** _____

To: McKenzie Medical Group 960 16th Street – Springfield, Oregon 97477

Health information that may be used / disclosed is limited to the following: ☐ Progress notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History & Physical ☐ Consultations ☐ Lab ☐ Pathology Report ☐ Operative Report
☐ Imaging/X-Ray (images) ☐ X-Ray Reports ☐ Entire Record
☐ Other (Specify): _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____
From (date): _____ To (date): _____

Health Information to be released to the above-named agency / individual is to be used / disclosed for the following purposes(s):
☐ At request of patient ☐ Treatment / Consultation ☐ Research ☐ Marketing ☐ Billing or claims payment
☐ At request of employer ☐ Other: _____

"Health information" identifies you (the patient) by name and includes other demographic information about you. "Health information" may include, but is not limited to: Medical records, Imaging films, slides, CD/DVD, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol abuse, drug abuse, communicable diseases including HIV status and / or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐ Yes ☐ No If applicable, I agree to the release of my medical or billing records containing the sensitive information above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If search-related Health Information is used or disclosed for continued research purposes, and expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature (except as indicated above) unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPPA prohibits such condition. If condition is permitted, refusal to sign the authorization may result in denial of care or coverage.

Notice to receiving agency or individual: This information is to be treated in accordance with HIPPA privacy regulations.

_____ _____/____/_____ _____
Patient's or Authorized Personal Representative's Signature *Date of signature* *Time*

_____ _____
Relationship to Patient / Authority to Act on Patient's Behalf *Interpreter, If Utilized*

_____ _____/____/_____ _____ _____
Staff Witnesses Signature *Date of signature* *Time* *Expiration date or Event*

☐ ***Signature validated against driver's license or signature in Medical Record**