Exceptional Health Care Records Release Form and Authorization for use & disclosure of Protected Health Information

Exceptional Health Care 1755 Coburg Rd, Bldg 6, Eugene, OR 97401 Ph: 541- FAX: 541-

Release PHI to: _____

OR Obtain PHI from: _____

Address: _____

Phone: _____ **Fax:** _____

Regarding: Patient Name: _____ **DOB:** _____

_____

Consisting of:

☐ **Lab reports** ☐ **Medical records needed for continuity of care** ☐ **Most recent ___ year history**
☐ **Pathology reports** ☐ **Chart Notes/Progress Sheets** ☐ **Emergency and Urgent Care records**

☐ **This authorization is limited to the following treatment:** _____
☐ **This authorization is limited to the following time period:** _____
☐ **For the purpose of Transfer of Primary Care**

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** _____**Mental health information**

_____**Genetic information** _____**Drug/alcohol diagnosis, treatment or referral information**

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.

PROVIDER 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 circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. 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 Exceptional Health Care, 1755 Coburg Rd, Bldg 6, Eugene OR 97401 and state that your are revoking this authorization

I have read this authorization and understand it.

Signature of Patient: _____ **Date:** _____

By: _____ **Relation to Patient:** _____

Unless revoked this authorization expires: _____