Authorization for the Release of Health Information

In order to allow SRCHC to request records from your previous providers, we request that you complete this form. Completion of this form is optional and not required to establish care at SRCHC, but helps to ensure sufficient continuity of care for the patient.

I authorize _____,_____
(Physician name) (Address and/or phone/fax)

to use and disclose specific health information re: _____ _____
(Patient Name) (DOB)

to **SouthRiver Community Health Center, P.O. Box 12 Winston, OR 97496, Fax: 541-492-4553,** for the purpose of *(check all that apply):* ☐ Continuity of Care ☐ Phone Conferencing ☐ Other _____

Please include the following *(check all that apply):*
☐ Chart notes ☐ Lab/Path reports ☐ Radiology reports ☐ EKG reports ☐ Diagnostic testing ☐ Immunization records ☐ Other, please specify: _____from date patient was last seen.
(Specify time frame, diagnosis, or specific reports)

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this authorization or to the extent you signed this authorization as a condition to insurance coverage. To revoke this authorization, please contact our office. Unless revoked earlier or otherwise indicated this authorization will expire **180 days** from the date of signing and shall remain in effect for the period needed to request.

_____ I consent to the disclosure of my HIV/AIDS information.

_____ I consent to the disclosure of my mental health information.

_____ I consent to the disclosure of my genetic testing information.

_____ I consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____
Patient or Guardian/Personal Representative signature (circle one) **Date**

_____ _____
Printed name of Patient **Printed name of Signatory and relationship, if not Patient**

3/2018