Family Practice Group

A Rogue Valley Physicians, PC clinic

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

From: Family Practice Group
229 Stewart Avenue
Medford, OR 97501-3663
Phone: 541-779-5531
Fax: 541-618-6452

☐ Caryn Belafsky, MD
☐ Ashley Peterson, MD
☐ Jill Celestskye, FNP
☐ Julie Lucero, PA-C
☐ Rex Strickler, PA-C
☐ Eric Ring, MD
☐ Tom Margulies, MD
☐ Dea Collins, MSA, FNP
☐ Denise Ledbetter, PA-C

To: _____
(Name of hospital/ health care provider)

_____
(Address, phone, and fax number of provider)

To disclose a copy of the medical information for:

_____ _____ _____
(Name of patient) (Date of Birth) Social Security Number

Purpose of Disclosure (circle one): Permanent Transfer Consultation Other

Information to be Used or Disclosed

By initialing the spaces below, I specifically authorize the disclosure of the following medical records, if such records exist:

___Hospital records (including nursing records and progress notes)
___**Most recent five-years records**
___Transcribed hospital records
___Medical records needed for continuity of care
___Laboratory reports
___Billing statements
___Pathology reports
___Diagnostic imaging reports
___Clinician office chart notes
___Physical therapy records
___Emergency and urgent care reports
___Other_____

___**OR** Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

PROTECTED OR SENSITIVE INFORMATION: I UNDERSTAND THAT CERTAIN INFORMATION CAN NOT BE RELEASED WITHOUT SPECIFIC AUTHORIZATION AS REQUIRED BY FEDERAL\STATE.
***BY INITIALING*, I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED OR SENSITIVE INFORMATION:**
_____ **HIV/AIDS/STD** related records
_____ **Genetic testing** information
_____ **Mental health** information
_____ **Drug/alcohol diagnosis**, treatment or referral information

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Family Practice Group. You should contact the Office Manager/Compliance Officer to terminate this authorization. The only exception is when action has already been taken in reliance on the authorization.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
(Date) (Signature of patient or person authorized by law)

_____
Relationship of Patient Representative to Patient (if signed by other than the Patient)