

Rehabilitation Medicine Associates, P.C.
1040 NW 22nd Ave., Suite 320 • Portland, OR 97210 • 503-413-6294 Office • 503-413-7780 Fax
Authorization for Release of Health Care Information

Patient Information (Please Print):

Name: _____ Date of Birth _____ SS # XX-XXX-_____

Information to be release from: _____

(Full name of Designated Facility or Provider)

(Address)

(City, State and Zip Code)

Information to be sent to: _____

(Full name of designated recipient -REQUIRED)

(Address-REQUIRED)

(City, State and Zip Code)

(Fax Number)* *Optional-see statement below*

Information to be Released:

- The most recent 2 years of pertinent information (Chart Notes, Labs, X-Rays and Special Tests)
- All Medical Records
- Specific Information (Please Specify): _____

Purpose for which Disclosure is Being Made: (Please Check One of the Following)

- Attorney
- Insurance
- Doctor
- Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** Include the following information from the records to be released (please initial):**

_____ Drug/Alcohol abuse/treatment & diagnosis

_____ Sexually Transmitted Disease

_____ HIV/AIDS diagnosis/treatment & testing

_____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patient posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may not longer be protected under privacy laws.

***Transmission Via Fax to Noncovered Entities:**

If you wish to have your personal health information sent to a non-covered entity, which is a location that is not part of your continuation or coordination of your medical care, (example: your employer or your home fax) we will include a confidentiality statement, but the integrity and security of the recipient and/or machine cannot be guaranteed by this office.

Permission to Fax to Noncovered Entities:

_____ (Initial Here) I understand the risks described above and consent to have my personal health information transmitted to the fax number provided.

Signature _____ Date _____

(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of the patient.]

This authorization will expire in 1 year from the date signed.

Possible Copying Fee Required

Verification Method (Circle one) ID Signature Challenge Questions Other _____ Initials _____