PHYSICIANS' MEDICAL CENTER, P.C.

2435 NE Cumulus Avenue Suite A
MCMINNVILLE, OR 97128
TELEPHONE (503) 472-6161 FAX (503) 434-6290

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize:

Physicians' Medical Center, PC
2435 NE Cumulus Ave Ste A
McMinnville, OR 97128

To use and disclose a copy of the specific health information described below regarding:

_____ _____ _____/_____/_____
(Name of patient) *(Date of Birth)* *(Social Security #)*

_____ _____
(Address of patient) *Patient's Telephone #*

_____
(City, State, Zip Code) *Email*

Consisting of: Dates of Health Care Information to Be Released: From (date)_____ **To (date)**_____

(Check all that apply) * Please refer to Photocopy Charges Form*

_____Clinic notes
_____History and Physical examinations
_____Discharge summary
_____Laboratory Reports
_____Other_____
_____Consultation reports
_____Operative reports
_____ X-ray/Diagnostic images
_____ EKG, EEG

To: _____
(Name of Doctor, Practice, Agency or Person Who is to Receive this HealthCare Information)

_____
(Address of recipient)

_____
(City, State, Zip Code)

Purpose of Request: _____Treatment/Consultation ____Transfer of Care ____Billing or Claims ____At the Request of the Patient

Other:_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release :
I understand that if my medical or billing record contains information in reference to : drug and /or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. ☐ **Yes** ☐ **No Initials**____

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and /or treatment, I agree to its release. ☐ **Yes** ☐ **No Initials** _____

Time Limit & Right to Revoke Authorization: This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services unless specified above under Purpose of Request. 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. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to the **Privacy Officer** at 2695 Tanger Drive Suite 100 McMinnville, Oregon 97128 and state that you are revoking this authorization.

Re-disclosure: I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.
Unless revoked this authorization will expire **180 days** or on the following date or event : the_____day of _____,200_____

Signature_____ Date:_____
(Signature of Patient or Legally Authorized Representative)

Description of relationship to patient:_____ ☐ I would like the records mailed ☐ I will pick up the records

Office Use Only: Processed by_____(Employee Name) Date_____
Mailed ☐ Faxed ☐ Other:_____