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

Patient Information:

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

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

_____ _____
(City, State, Zip Code) *(Patient's Email)*

I Authorize Information to be Released *From*:

PHYSICIANS' MEDICAL CENTER, P.C.

2435 NE CUMULUS AVE STE A

MCMINNVILLE, OR 97128

PHONE: 503-472-6161 FAX: 503-434-6290

Information to be Released *To:*

_____
(Name of Provider/Facility/Person who is receiving the information)

_____
(Address)

_____
(City, State, Zip Code)

_____ _____
(Phone) *(Fax)*

Type of Information:

_____All Records _____Office Visit Notes _____Consult Reports
_____Hospital Reports _____Imaging Reports _____Laboratory Reports
_____Other_____

Dates to be Released: _____All _____Last 2 years Records from Date_____to_____

Method for Delivery: _____Fax _____Mail _____Email _____Pick Up

Purpose of Request: _____Treatment/Consultation _____Transfer of Care _____Billing or Claims _____At the Request of the Patient

Other:_____

Protected or Sensitive Information:
I understand that if my medical or billing record contains information in reference to the specific type of information below, laws of 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 space next to the type of information.

_____**HIV/AIDS** _____**Genetic Testing** _____**Mental Health Information** _____**Drug/Alcohol Treatment Information**
(Initials) *(Initials)* *(Initials)* *(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 2435 NE Cumulus Ave Ste A, 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 in **180 days** or on the following date _____.

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

Description of relationship to patient: _____

Office Use Only: Processed by_____ (Employee Name) Date_____