AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION Per ORS 192.553

I authorize to release records FROM:

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____Fax:_____

I authorize to release records TO:

Complete Integrative Care
3156 State St.
Medford, OR 97504
P: (541) 773-9772
F: (541) 773-1113

PATIENT INFORMATION

Name:_____DOB:_____Social Security #:_____

Address:_____City:_____Zip Code:_____

INFORMATION TO BE RELEASED

___Clinician office progress note
___ Diagnostic imaging report
___ Laboratory report
___ Pathology report

Other:_____

Dates of service from:_____to:_____(Please note that only the two most recent records will be released if not specified)

My personal health information will be released on my behalf for the following purpose: (check all that apply)

_____ Transferring of Care
_____ Continuity of Care

If the information to be disclosed contains any information related to HIV/AIDS, mental health diagnoses or medication management, genetic testing, drug/alcohol diagnosis, treatment and or referral information additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed by signing below.

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 testing information and drug/alcohol diagnosis, treatment or referral information. Provider has up to 30 days to release medical records according to Oregon law and the Health Information Privacy Protection Act.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure.

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.

I have read this authorization and I understand it. Unless revoked, this authorization expires when records are released.

_____ _____
Signature of patient or representative Date