Authorization for Release of Medical Information

Patient's Full Name (Print): ____

Previous Name: ___________________________ Date of Birth: ____________________

Release From: ____
(Clinic, Dr, or
Hospital) ____

____

Release To: ____
(Clinic, Dr. or
Hospital) ____

HIPAA laws require that we disclose only the "minimum information necessary to achieve the purpose" of the medical information request.
Please indicate below what information is needed for continuity of care, i.e. pap smear, mammogram, well woman visit, most recent lab work, surgery operative note:

____

If the information to disclosed contains any of the types of records or information listed below, additional laws relating to the 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 applicable space next to the type of information.

_____HIV/AIDS-related records

_____Genetic testing information

_____Mental health information

_____*Drugs/alcohol diagnosis treatment, or referral information

*Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information to be disclosed.

Purpose of Disclosure:

______ Continuity of Care

______ Personal

______ Change of Doctor

______ Other (Specify)

Unless revoked earlier, this consent will expire 180 days from date of signing. To revoke this request, please contact Dr. O'Sullivan's office at the above phone number.

Patient Signature: ___________________________ Date: ______________ Phone: ______________
(Or Patient Representative)

Please Note: There is a $25 charge for a personal copy of your records.
The Oregon Medical Association allows us 30 days to copy and release records.