Hope Family Medicine, INC.
Hope delayed makes the heart sick, but a longing fulfilled is a tree of life.

Eric North, MD • Phoenix Senna North, MD
530 Welch St • Silverton, Oregon 97381
Phone 503.874.6026 • Fax 503.874.6061
www.hopefamilymedicineonline.com

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name _____ Previous Name _____ Date of Birth _____

I, the patient/guardian, authorize:

Name of Provider _____ Phone Number _____ Fax _____

Address _____ City _____ State _____ Zip Code _____

To disclose my medical records to:

Name _____ Phone Number _____ Fax _____

Address _____ City _____ State _____ Zip Code _____

The following information may be disclosed:

☐ Chart Note(s)
☐ Laboratory Report(s)
☐ Diagnostic Imaging Report(s)
☐ Other _____

If the information to be disclosed contains any of the 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.

_____ Alcohol/Drug Abuse
_____ HIV/AIDS Test Results
_____ Mental Health/Developmental Disabilities
_____ Genetic Testing

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol abuse, treatment or referral information.

Purpose for the release of records:

_____

You do not have 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 circumstances when the refusal to sign means you will not receive health care services is if the health care services are solely for he purpose of providing health information to someone else an the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may not longer be used or disclosed for he purposes described in the written authorization. The only exceptions 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.

Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have read this information and understand it:

Print Name _____

Signature _____ Date _____