AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize:
Clear Creek Family Practice
18173 Redwood Hwy POB 847, Selma OR 97538
Phone: (541) 597-2464 Fax: (541) 597-4280

To release information requested for:

________________________________ **D.O.B.** ________________

(Patients Name) (Date of Birth)

To: ________________________________ For the purpose of: Transferring Care

________________________________ ________________________

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

- ___ All hospital records (including nursing records and progress notes)
- ___ Diagnostic imaging reports   ___ Pathology reports   ___ Other (Explain Below)
- ___ Medical records needed for continuity of care   ________________________
- ___ Clinician Office Chart notes
- ___ Laboratory reports
- ___ Emergency and Urgency care records
- ___ Please send the entire medical records (All information) to the above-named recipient

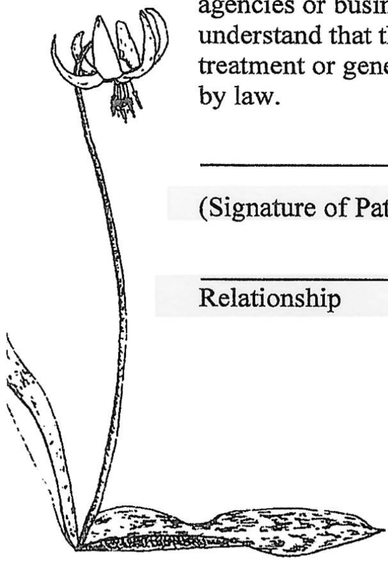
I authorize the information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

- ___ *HIV/AIDS - related records (Copies will not be released to inmates while incarcerated)
- ___ *Genetic testing information
- ___ *Mental Health-list specific info requested ____________________________
- _____**Alcohol and Drug information

**PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is limited to the following time period ________________________

My signature indicates that I authorize the disclosure of the above information and understand the following:
I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.
I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. 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 understand this change will not affect information that has already been shared.
I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.



________________________________ ________________________

(Signature of Patient Or Guardian (Date)

________________________________ (______)__________________

Relationship Contact phone number for questions

Clear Creek Family Practice

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