CAMAS SWALE MEDICAL CLINIC AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization*.

Patient Name (Printed)	DOB	Phone Number	
Address	City	State	Zip

I authorized information to be released:

From:_____ _____
Individual or Facility Phone Number

_____
Mailing Address, City/State, Zip

To: _____Camas Swale Medical_____ 541-658-5301 Phone
uite 844-628-7039 Fax
Creswell, OR 974726

The purpose of this request is:
- □ Refererred Medical Care (Specialist)
- □ Transferring Primary Care
  - □ Relocation
  - □ Personal Preference
  - □ Other_____
- □ Clinical Research
- □ Billing Purposes
- □ Personal Request
- □ Other_____

The purpose of this request is at the request of the individual

TYPE OF INFORMATION TO BE RELEASED
_____*All Medical Records (last 2 years of information unless otherwise indicated)
_____*Entire Record (Birth to present unless otherwise indicated)
_____Physician Notes
_____Imaging Reports and/or Films (Circle on or both)
_____Lab and/or Pathology Reports (circle one or both)
_____Hospital Records/Consultations
_____Physical Therapy Records
_____Worker's Comp Injury Records
_____Immunization Records
_____Billing Information
_____Other _____
* "Entire Record" and "All Medical Records" include ALL Billing, Imaging, and Mecial record information.

Must be initialed to be included in other documents
_____HIV/AIDS-related records
_____Mental Health Counseling and/or treatment information, including information regarding Depression, Anxiety, and Stress.
_____Genetic Testing Information
_____Drug/alcohol diagnosis, treatment or referral information (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of info is to be disclosed). If applicable complete restriction box below.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at Camas Swale Medical, 170 Melton Rd, Creswell OR 97426, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. This Authorization will expire on the earlier of_____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Restrictions - Initial & Complete if applicable:
_____This authorization is limited to the following time period:_____

_____This authorization is limited to the following time treatment: _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I specifically give authorization to FAX my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information._____(initials)

_____ _____ _____
Signature of patient or legally responsible person* Relationship to Patient Date

*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)