AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____ Date of Birth: _____/_____/_____

I authorize _____ _____
Name Fax

_____ _____
Address City State Zip Phone

To release my health information that I have identified below to:

West Hills Healthcare Clinic
2163 NW 2nd St.
McMinnville, OR 97128
Phone (503) 472-4197 Call for fax number if *LESS* than 20 pages*
***RECORDS OVER 20 PAGES *MUST* BE MAILED**

for the purpose(s) of: _____Expires in 180 days or: _____

Check the spaces below to specifically authorize the release of the following health information and/or records, if such information and/or records exist:

_____**ALL RECORDS**
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five-year history
_____ Emergency and urgent care records
_____ Other:_____
_____ Clinician office chart notes
_____ Dental Records
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Billing statements

Each of the following items MUST BE INITIALED to be included in the use or disclosure of other health information:

_____ *HIV / AIDS related health information and/or records

_____ * Mental health information and/or records

_____ * Genetic testing information and/or records

_____ * Drug/Alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed:_____

_____ * Psychotherapy notes (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with another authorization).

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to West Hills Healthcare Clinic.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my information under the applicable state or federal law and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____ _____
Signature of Individual ***Print Name*** ***Date***
Or

_____ _____
Signature of Legal Representative ***Description of Legal Authority***