Authorization to Disclose Medical Records To Outside Entity

Outgoing Records Release

La Pine Community HEALTH CENTER

Medical Records Department · Po Box 3300 · La Pine, OR 97739 · Phone: (541) 536-3435 · Fax: (541) 536-8047

Patient Name: _____ DOB: _____ LCHC PCP: _____

By signing this form, I authorize La Pine Community Health Center to release confidential health information about me, by releasing a copy of my medical records, a summary or a narrative of my protected health information and all indicated materials to the entity listed below:

Release Authorized To:

Name: _____ Provider: _____

Address: _____ Phone: _____

City: _____ State: ____ Zip: _____ Fax: _____

Why are you requesting your records being released?

☐ Change of PCP ☐ Moved ☐ Treatment/Continuing Care ☐ Disability/FMLA ☐ Personal

☐ Back To Work ☐ Verify Attendance ☐ Insurance ☐ Legal ☐ Other (Specify): _____

Check all information to be disclosed to the above party:

Range of Information to Release:

☐ Last Year ☐ Last 2 Years

☐ All ☐ Other (Specify):

_____

☐ Complete Medical Record ☐ Immunization Records

☐ Medication List ☐ Pathology Reports

☐ Radiology Reports ☐ Labs

☐ Progress Notes ☐ Other (Specify): _____

Confidential Information Disclosure Agreement:

If you **DO NOT** want any of your confidential information released, check this box

☐ By checking this box you are refusing to release any of the confidential information in your record

*****To release confidential information you MUST initial below*****

I consent to the release of the following specific confidential health information:

_____ (Initial) Mental Health

_____ (Initial) Substance Abuse Treatment Information

_____ (Initial) I consent to the release of any positive or negative test results for AIDS or HIV infections, antibodies to AIDS, or infections with any other causative agents of AIDS with the rest of my medical records.

Record Delivery Method:

☐ Mail (to the address listed above) ☐ Local Pick-Up (circle one: La Pine, Gilchrist, Sunriver, Christmas Valley)

☐ Fax (to the number listed above) ☐ MyChart (active OCHIN MyChart account required) **FREE**

I understand that La Pine Community Health Center will provide this information within 30 days from the receipt of the COMPLETED request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Oregon State laws, Federal laws and the Health Center's policies. There will be a minimum $25.00 copy fee for patients to receive a paper copy of their records (ORS 192.521). Records released electronically to MyChart are free of charge.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____