Evergreen FAMILY MEDICINE
A Division of Centennial Medical Group
2570 NW Edenbower Blvd, Suite 100
Roseburg, OR 97471
Phone: (541) 677-7200
Fax: (541) 229-3309

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name _____ Birth Date_____
(PLEASE PRINT) LAST FIRST MI

Reason for release (**i.e. transferring care**): _____ Previous Last Name: _____

INFORMATION TO BE RELEASED **BY**:	INFORMATION TO BE RELEASED **TO**:
☐ Evergreen Family Medicine	☐ Evergreen Family Medicine
☐ _____	☐ _____
Organization/Person	**Organization/Person**
_____	_____
Street Address	**Street Address**
_____	_____
City State Zip	**City State Zip**
_____	_____
Phone Fax	**Phone Fax**

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ **LAST FULL YEAR OF CHART NOTES FROM DATE OF LAST SERVICE**
- ☐ **LAST FULL YEAR OF LABS/PATHOLOGY FROM DATE OF LAST SERVICE**
- ☐ **LAST FULL 2 YEARS OF IMAGING REPORTS FROM DATE OF LAST SERVICE**
- ☐ **MOST RECENT REPORTS:** ☐ **EKG** ☐ **MAMMOGRAM** ☐ **COLONOSCOPY** ☐ **PAP SMEAR** ☐ **DEXA/BONE DENSITY**
- ☐ **MY HEALTH INFORMATION RELATING ONLY TO THE FOLLOWING TREATMENT OR CONDITION:** _____
- ☐ **MY HEALTH INFORMATION ONLY FOR THE FOLLOWING DATE(S):** _____
- ☐ **OTHER:** _____

INITIAL ONLY!!! **PROTECTED OR SENSITIVE INFORMATION:** I understand that certain information cannot be released without specific authorization as required by Federal/State Law. **BY INITIALING,** I authorize the release of the following protected or sensitive information:

_____ HIV/AID related records **_____ Drug/Alcohol diagnosis, treatment or referral information**
_____ Mental Health Information **_____ Genetic Testing Information**

- **MINORS AGE 13-17:** A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to : contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under Federal law.
- I also understand that the information used or disclosed pursuant to this authorization may be subject to disclosure of HIV/AIDS information, mental health information, generic testing information and drug/alcohol diagnosis, treatment or referral information.
- You do not need 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 circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purposes of providing health information to someone else and the authorization is necessary to make the disclosure.
- You may revoke this authorization **IN WRITING** at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send or deliver a written statement to:
Evergreen Family Medicine; a division of Centennial Medical Group
Medical Records Custodian
2570 NW Edenbower Blvd, Suite 100
Roseburg, OR 97471

PLEASE STATE CLEARLY THAT YOU ARE REVOKING THIS AUTHORIZATION

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICAN OR HEALTHCARE FACILITY.

I have read this authorization and I understand it. Unless specified, this authorization will expire one year from date signed. _____
(Specified Expiration Date)

_____ _____ _____
(Signature of Individual or Personal Representative) **(Date Signed)** **(Description of Personal Representative's Authority)**