High Lakes Health Care

Bend P: 541.389.7741 F: 541.278.8375 – Redmond Primary P: 541.548.7134 F: 541.278.8350
Sisters P: 541.549.9609 F: 278.8379

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Please note: Medical records sent to High Lakes Health Care must be on paper, discs will not be accepted.

I, [patient]_____SS#_____ DOB_____

authorize [provider name] _____

at [address]_____
(We will not process this request unless given complete name, address and fax number.)
to use and/or disclose my health information as identified below to:
High Lakes Health Care –
[name of High Lakes Provider] _____
for the following purpose(s): [describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]_____.

By ***INITIALING*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

____Please send the entire medical record (*all information*) to the above named recipient.

____All hospital records (including nursing records & progress notes)	____Clinician office chart notes
	____Dental records
____Transcribed hospital reports	____Laboratory reports
____Medical records needed for continuity of care	____Pathology reports
____Most recent five-year history	____Diagnostic imaging reports
____Emergency and urgent care records	____Billing statements

____Other_____

*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. Federal law prohibits the re-disclosure of such information.)

_____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke the authorization at any time by giving written notice to *High Lakes Health Care*'s Privacy Officer. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or upon **[insert applicable date or event of expiration] _____.**

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 have copies of 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 redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws 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 or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual
(A copy of this signed form will be provided to the individual and/or the individual's legal representative.) 10.25.16