Patient Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

I authorize: ☐ **Mid-Columbia Medical Center**
1700 E. 19th Street
The Dalles, OR 97058
Fax: (541) 296-7617

☐ **Mid-Columbia Outpatient Clinics**
Clinic or Provider : _____
Phone: _____
Fax: _____

Information may be: ☐ Provided to ☐ Received from

_____
Facility/Person Phone #

_____
Street Address City State Zip

The information will be used on my behalf for the following purpose: _____

☐ Provide records in electronic format, when possible: ___Thumb Drive ____ MyChart

Information to be released:	**By initialing in the spaces below, I authorize release of the following information:**
☐ Discharge Summary ☐ History & Physical Exam ☐ Diagnostic Imaging Reports ☐ Image CD ☐ Emergency Dept. Reports ☐ Pathology/Laboratory ☐ Clinic Notes ☐ Other: _____ Treatment Dates: _____	( ) HIV/AIDS related information ( ) Mental health information ( ) Drug/alcohol diagnosis, treatment or referral information ( ) Genetic testing information Date range: _____

- I understand that this authorization will automatically expire in 180 days from the date of my signature or on _____.
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Mid-Columbia Medical Center Medical Record Department, 1700 E. 19th Street, The Dalles, Oregon 97058. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, treatment or referral information.
- I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits.
- I understand that the above-named clinic is part of Mid-Columbia Medical Center or Outpatient Clinics, and in signing this request records may be sent from any of the clinics.
- I understand that I will be given a copy of this authorization form after signing.
- I have been advised there may be a fee assessed for providing this information. _____(initials).

_____
Signature of Patient or Legal Representative *Date* *Relation to Patient*

Description of personal representative's authority: _____

Method of delivering physical information:
____ I will pick up the records in the Health Information Management Department. ____ Please mail the records.