MCKENZIE PEDIATRICS

AUTHORIZATIONS TO USE/DISCLOSE HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by a law to give this authorization.

I authorize information to be released

FROM:_____
Name of Facility

_____
PO Box/Street Address

_____
City, State, Zip

Please send my records

TO: ____**Mckenzie Pediatrics**_____
Name of Facility

_____**1442 South A Street**_____
PO Box/Street Address

_____**Springfield, OR, 97477**_____
City, State, Zip

PURPOSE OF THIS RELEASE:

˚Medical Care ˚Transfer of Care ˚Relocating ˚Legal ˚Billing ˚Request of Individual ˚Other_____

TYPE OF INFORMATION TO BE RELEASED:

___ All Medical Records (Records released will be limited to last 2 years of information unless otherwise indicated)
___ Physician Notes
___ X-Ray Reports
___ Lab and/or Pathology Reports
___ Hospital Records/Consultations
___ Physical Therapy Records
___ Worker's Comp Injury Records
___ Other_____

Must be initialed to be included in other documents

___ HIV/AIDS – related records

___ Mental Health Counseling and/or treatment information, including information regarding Depression, Anxiety and Stress

___ Genetic Testing Information

___ Drug/alcohol diagnosis, treatment or referral information (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of info is to be disclosed). If applicable complete restriction box below

Your health care and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

1) Creating health information about you to be disclosed to a third party: or
2) For the purpose of research.

You have the right to revoke the Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at Mckenzie Pediatrics, 1442 South A Street Springfield, OR, 97477, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Restrictions – Initial and Complete if applicable:

_____ This authorization is limited to the following **time period** _____

_____ This authorization is limited to the following **treatment** _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____
Patient name (printed) DOB Phone Number

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Signature of patient or legally responsible person Relationship to Patient Date

I specifically give authorization to **FAX** my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information. _____ **(initials)**