**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 Please send my records

**FROM:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TO:** \_\_\_\_**Mckenzie Pediatrics** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Facility Name of Facility

­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ **1442 South A Street**\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PO Box/Street Address PO Box/Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ **Springfield, OR, 97477** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip City, State, Zip

sS

**PURPOSE OF THIS RELEASE:**

̊Medical Care ̊Transfer of Care ̊Relocating ̊Legal ̊Billing ̊Request of Individual ̊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

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)**