Summit Health
1501 NE Medical Center Drive | Bend OR 97701
Medical Records Department
Phone: 541-706-6509 | Fax: 541-318-3113

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____
Last **First** **MI** **Date of Birth *Required***

Home Address:_____
Street Address

City_____ **State**_____ **Zip Code**_____

Telephone: (Day)_____**(Evening)**_____

Purpose of Release Request:

- ☐ At the request of the patient (when the patient initiates the authorization)
- ☐ Changing Providers
- ☐ Legal Reasons
- ☐ Relocating outside the area
- ☐ Doctor Consultation/referral
- ☐ Other:

The following Health Information about me may be used and disclosed (*check each box that applies*):

- ☐ Most recent 2-year history for continuity of care
- ☐ Specific Provider Notes: _____
- ☐ Immunizations
- ☐ Laboratory/Pathology – *Specify date(s)* _____
- ☐ Cardiology
- ☐ Pulmonology/Sleep Studies- *Specify date(s)* _____
- ☐ Urgent Care
- ☐ Imaging studies- *Specify date(s)* _____
- ☐ Ophthalmology
- ☐ Rheumatology
- ☐ Operative/Procedure Reports- *Specify date(s)*_____
- ☐ Gastroenterology
- ☐ Dermatology
- ☐ Other: _____

I specifically authorize the disclosure of the following information that may have additional state and federal protections:

- ☐ Mental Health Diagnosis & Treatment
- ☐ Drug or Alcohol Addiction Diagnoses or Treatment
- ☐ HIV/AIDS Testing, Diagnoses, & Treatment
- ☐ Genetic Testing Results
- ☐ Sexually Transmitted Disease Testing, Diagnoses, & Treatment

I authorize the information designated above to be released from:	**I authorize the information designated above to be released to:**
Name of Facility:	Name of Facility:
Name of Doctor or Department:	Name of Doctor or Department:
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:

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- ☐ **PLEASE MAIL MY RECORDS TO THE RECIPIENT LISTED ABOVE**
- ☐ **PLEASE MAIL MY RECORDS TO ME AT MY HOME ADDRESS**
- ☐ **I WILL PICK UP RECORDS IN PERSON**

TERM: This authorization will expire upon SH's release of my health information as needed to fully accomplish the purpose(s) listed below or 90 days from the date signed.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used and disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal and/or state confidentiality rules.

I hereby release SH from any liability which may result from this disclosure of medical information, or which may arise as a result of the use of information contained in the information released.

I understand that I have the right to revoke this Authorization, at any time before SH's reliance thereon, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in SH's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to:

Summit Health
1501 NE Medical Center Drive
Bend, OR 97701
ATTN: Privacy Officer/Liaison

If you have any concerns, you may contact the Privacy Officer/Liaison at 541-706-6507.

Signature of Patient _____ Date _____

If Patient is a minor or is otherwise unable to sign this Authorization, please obtain the following signatures:

_____	_____	_____
Signature of Personal Representative	Description of Personal Representative's Authority (i.e. POA, legal guardian- documentation required)	Date