LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

AUTHORIZATION TO RELEASE/DISCLOSE INFORMATION

Patient or Student Full Name	Date of Birth	Record or Account Number

I authorize the release of my health information <u>from</u>:
(***Who*** has the information you want released? Please list the specific Hospital or Clinic.)

Place Site Location Stamp Here

Name
Address
City
State
Zip

I authorize the release of my health information <u>to</u> the following person(s) or organization: (***Where*** do you want the information sent or ***who*** may have the information?)

Place Site Location Stamp Here

Name
Address
City
State
Zip

For the following purpose(s): □ Continuity of Care □ Copies for Own Use □ Insurance □ Legal
□ Other (specify) _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. We are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to a family member or another individual, please indicate their name and relationship below:

I authorize La Clinica to disclose my medical or billing information to the following individual(s):

Individual's Name: _____ **Relationship to Patient:** _____
Individual's Name: _____ **Relationship to Patient:** _____

□ Release of Medical Records □ Verbal Discussion □ No records sent at this time, please keep on file

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<u>Information Requested</u>:

□ Complete Record – Past Two Years	□ Complete Record	□ Consultations
□ Dental Exams (including radiographs)	□ Discharge Summary	□ ER Report(s)
□ History & Physical	□ Medical Exam(s)	□ Health Screenings
□ Safety Concerns/Suspected Abuse	□ Immunizations	□ Inpatient Information
□ Laboratory Reports	□ Medication Records	□ Counseling/Mental Health Support
□ Probation & Parole Information	□ Educational Information	□ Special Education Records
□ Office/Progress Notes(s)	□ Operative Report	□ Outpatient Information
□ Imaging Report(s)	□ Itemized Billing Records	□ Other: _____

Dates of Care to be Released: _____ **to** _____

I UNDERSTAND THAT federal or state law may restrict disclosure of the following sensitive information. Therefore, I understand and agree that my initials next to each type of information **will allow that information to be released**:

Initials: _____ Drug Abuse Diagnosis/Treatment
Initials: _____ Alcoholism Diagnosis/Treatment
Initials: _____ Sexually Transmitted Disease
Initials: _____ Mental Health Diagnosis/Treatment (Excludes psychotherapy notes)
Initials: _____ Sickle Cell Anemia
Initials: _____ Genetic Testing Results
Initials: _____ Psychological Evaluation Records
Initials: _____ Mental Health Assessment Summary, Attendance & Progress, Discharge Summary
Initials: _____ HIV/AIDS Test Results

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 some of the sensitive information described above. (45 CFR§164.508 (c)(2)(iii))

I am not required to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means I will not receive health services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (45 CFR§164.508 (c)(2)(ii))

I have a right to request, in writing, a list of protected health information disclosures as permitted under federal or state law.

I may revoke this authorization in writing at any time by sending a written statement to: La Clinica del Valle at 3617 S. Pacific Hwy., Medford, OR 97501

If I revoke my authorization, the information described above may no longer be used or disclosed for purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. (45 CFR§164.508 (c)(2)(ii))

In La Clinica's school-based health centers, protected information will be used or disclosed only when it is necessary to satisfy a particular purpose or carry out a function related to health and protection of a child's well being and ability to learn and succeed.

This authorization shall expire one (1) year after the date signed unless a different expiration date or event is entered here:

_____

_____ _____
Signature of Patient or Legal Representative/Guardian | Date

_____ _____
Printed Name of Patient/Legal Representative/Guardian | Relationship of Legal Representative or Guardian

_____ _____
Witness Signature | Printed Name of Witness

For Staff Use Only:

□ Patient Pick-Up □ Faxed □ Mailed □ Other _____

Staff Name: _____ Date: _____