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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

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

_____ _____ _____
(Print name of Patient) (Date of Birth) (Phone Number)

I hereby authorize the release of medical information regarding the patient named above by copy of medical records and/or by discussing the information in person or by phone.

TO: (Facility/Physician/Individual) **La Grande Family Medicine**

FROM: (Facility/Physician/Individual)
_____
Address_____(Phone) _____
City, State, Zip Code _____ **(Fax)** _____

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist.

Purpose of Disclosure:
____Medical ____Legal ____Insurance ____Personal ____Other (_____)
Specify Reason

Date Range: ____Most Recent 2 Year History
____Dates of Service From _____ to _____

Permission to fax information: _____No ____ Yes: I specifically consent to the faxing of my protected health information. All faxed material will contain a confidentiality statement. However; I understand confidentiality at the receiving end cannot always be guaranteed.

Type of Information to be released:

_____Any and all medical records needed for continuity of care (chart notes, labs, x-rays, special tests, etc)

_____Chart Notes _____ Labs/Pathology Reports _____ X-ray Reports _____Special Tests

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by Federal State Law. By **initialing**, I authorize the release of the following protected or sensitive information:
_____Drug Abuse Diagnosis/Treatment _____Mental Health Treatment
_____Alcoholism Diagnosis Treatment _____AIDS/STD Test Results & Related Information

This authorization may be revoked at any time. The only exception is when action had been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in one (1) year from the date of signing and shall remain in effect for the period reasonably needed to complete the requirement.

_____		_____	_____/_____/_____
Signature of Patient	OR	Signature of Authorized Person	Date