Erin Haines, PA-C
110 Main Street
PO Box 186
Moro, OR 97039
Phone: 541-565-3325
Fax: 541-565-3617

Patient Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

All Previous Names: _____

I authorize Sherman County Medical Clinic to do the following ☐ Provide Information to:
☐ Receive Information from:

_____

Facility /Person Phone Number

_____

Street Address City/ State/ Zip Code

❖ The information will be used on my behalf for the following purpose(s): _____

Information to be released:	**By *initialing* in the spaces below, I authorize release of the following information:**
☐ Discharge Summary ☐ History and Physical Exam ☐ Laboratory Reports ☐ Diagnostic Imaging Reports ☐ Emergency Department Reports ☐ Medications ☐ Pathology Reports ☐ Medical Out-Patient Clinic Records ☐ Other: _____	_____ HIV/ AIDS related information _____ Mental Health information _____ Drug/Alcohol diagnosis, treatment, or referral information _____ Genetic testing information
Treatment Dates: _____	**Time Period:** _____

- I understand that this authorization will automatically expire in 180 days from the date of my signature or on (specify date) _____
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Sherman County Medical Clinic, 110 Main Street, PO Box 186, Moro, Oregon 97039. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and not longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, treatment or referral information.
- I understand that I need not sign this form to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits.
- I understand that I will be given a copy of this authorization form, after signing.
- I have been advised there may be a fee assessed for providing this information. _____ (initials)

_____ _____

Signature of Patient Date

_____ _____

Signature of Personal Representative (if necessary) Indicate relationship to Patient