Authorization to Release Health Records

1. Patient Information

Name ______________________

Address ______________________

____

Date of Birth ______________________

Primary Phone ______________________

Secondary Phone ______________________

2. Transfer Records From

Choose Only One:

- ◻ Harney District Hospital
- ◻ HDH Family Care
- ◻ High Country Health and Wellness or Harney County Public Health
- ◻ Mountain Sage Medical
- ◻ VA Clinic, Burns, OR

Note: Copy Fee May be Charged for Medical Records

◻ Other: Name ______________________

Address ______________________

____

Phone ______________________

Fax ______________________

3. What to Transfer and Purpose

What To Transfer

- ◻ 2 years prior from last date seen
- ◻ Specific Dates ______________________
- ◻ Chart Summary
- ◻ 10 Year Colonoscopy
- ◻ 5 Year Pap
- ◻ Other ______________________
- ◻ Include Substance Use Disorder Records

Purpose of Disclosure

- ◻ Change of Insurance or Physician
- ◻ Continuation of Care
- ◻ Referral
- ◻ Other ______________________

Authorization Expiration:______________________
(1 year if left blank)

4. Transfer Records To

ThriveWell Clinic
77 W Washington St
Burns, OR 97720

Office: 541 573 3000
Fax: 541 797 6158

Please Send Records by Fax

5. Authorization

The undersigned authorizes the health care facility listed in section 2 to transfer records described in section 3 concerning the patient described in section 1 to ThriveWell Clinic, as listed in section 4. I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug use. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocations 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 the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire as described in section 3. I understand 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. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of the information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization to Release Health Records and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

____
Signature of Patient/Parent/Guardian or Authorized Representative

____
Date

____
Printed Name

____
Relationship to Patient