McMinnville
829 NE Hwy. 99W
McMinnville, OR 97128
503-883-0333

I authorize the use and/or disclosure of the individual's health information named below as follows:

Patient Name: ____

Alias or Other Name**:** ____

Date of Birth**:** _________________

Name of Provider or Facility:

____

Name & Title of Provider/ Organization Name/ Individual (and Phone Number)

____

Street Address (and Fax Number)

____

City/ State/ Zip (This information must be provided)

REQUIRED:

I authorize AFHC to:
(Check all that apply)

☐ **Obtain Information**

☐ **Release Information**

☐ **Exchange information Bi-directionally**

For the purpose of: ☐ Patient Care ☐ Self: Personal Records
☐ Coordination of care and Services ☐ Other: ______________________

If requesting records for yourself the cost is $30 for up to 10 pages and 50 cents per page for pages 11-50 and 25 cents for each additional page over 50 as per Oregon policy 192.563

Records sent to another doctor's office for coordination of care does not have a fee.

Description or nature of information to be used and/or disclosed:
☐ Most recent _________of records ☐ Clinician office notes ☐ History & Physical Exams ☐ Consultations
☐ X-ray/Imaging Reports ☐ Laboratory reports ☐ Pathology Reports ☐ All Clinic Records
☐ Billing Statements ☐ Academic Records ☐ Psychological Reports ☐ Transcripts
Other (specify):____

If the information to be disclosed contains any of the following types of special information below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the space next to the type of information.

___*HIV/AIDS related information and/or records ___*Mental Health Information
___*Genetic Testing Information ___*Drug/Alcohol diagnosis, treatment, or referral information

Duration: This authorization shall begin immediately and remain in effect until (date):______________
Or not more than 12 months from the authorization date.

RESTRICTIONS: Information released will not be disclosed to any third party not identified on this form without specific written consent.
RIGHTS: You may refuse to sign this authorization and that you refusal to sign may not affect your ability to obtain treatment. The only circumstance when refusal to sign means you will not receive health care services if the services are solely for the purpose of providing health information to someone else and the authorization is necessary to make disclosure. You may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organization policy.
* **A Family Healing Center Has up to 30 (thirty) days to comply with your request.**
REVOCATION: You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to our

I have read this authorization, or it has been read to me, and I understand it.

Signed: ____ Date: ________________
(Patient or personal representative)
Description of personal representative's authority (relationship):____