



See reverse side for instructions to fill out this form.
Failure to follow instructions may result in processing delay.

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. PATIENT INFORMATION

PRINT Patient Name: _____
Birth Date (mm/dd/yyyy): _____
Previous Name(s): _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: (____) _____
Email: _____

****Note:** I acknowledge that Mid Valley Gastroenterology may charge a fee for obtaining records for personal use. The fee is \$10.00 for the first page and \$.25 each additional page plus postage. This fee covers time and materials used. _____(initials)

2. I AUTHORIZE MID VALLEY GASTROENTEROLOGY TO:

RELEASE INFORMATION TO: OBTAIN INFORMATION FROM: Check if same as address above

Organization or person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____ Fax: (____) _____
Email: _____

DELIVERY METHOD FOR RECORDS: Secure Email Fax Paper/Mail (may take longer to process) CD

3. PURPOSE OF RELEASE: Continuity of care Personal

4. INFORMATION FROM ____/____/____ TO ____/____/____ TO BE RELEASED:

ALL Medical records Operative report Lab/Pathology reports Radiology reports Billing records
 Other: _____

5. PATIENT AUTHORIZATION: I understand that, if the information to be disclosed contains any of the types of records listed below, additional laws relating to the use and disclosure of the information may apply.

BY INITIALING: I authorize Mid Valley Gastroenterology to release this protective information.

✓ Information released may include information regarding the testing, diagnosis or treatment of
____ HIV/AIDS ____ Sexually transmitted diseases ____ Chemical/alcohol dependency ____ Mental health
____ Genetic testing information

- ✓ By signing this form, you are authorizing the use or disclosure of your protected health information as listed above. This information may be subject to re-disclosure if the recipient is not required by law to protect the privacy of the information.
- ✓ You have the right to revoke this authorization at any time by sending a written statement to: Privacy Officer, Mid Valley Gastroenterology 3521 N Samaritan Dr., Suite 101 Corvallis, Oregon, 97330 that identifies the date you signed this authorization, the recipient of the information identified in this authorization, and state that you are revoking this authorization. This will not affect any actions already taken based on this authorization.
- ✓ Unless otherwise revoked, this authorization will expire on _____(date) or 180 days from the date of signing. You are under no obligation to sign this form, and you may refuse to do so. Treatment, Payment, Enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

6. SIGNATURE: _____ **DATE:** ____/____/____

*Legal representative _____ Relationship to patient: _____

*Documentation may be required to prove authority to sign on behalf of patient.

INSTRUCTIONS:

1. **PATIENT INFORMATION:** Print name of patient, birthdate, previous names used, address, phone number and email.
2. **RECIPIENT INFORMATION:** Print name, address, phone number, fax number and email address.
Delivery method: If Electronic delivery is preferred please PRINT the email address clearly.
3. **PURPOSE:** Check the box that applies to the reason the records are being requested.
4. **INFORMATION TO BE RELEASED:**
 - Medical records – Unless otherwise requested, we will only send two (2) years' worth of records. A maximum of 10 years of records can be sent.
5. **PATIENT AUTHORIZATION:** Please initial next to each type of protected information to allow release of said information. By initialing each type of protected information, you are not confirming you have said protected information or diagnoses. If you choose to not initial the protected information section, there will be a delay in the process of your medical records or possibly a denial of the request.
6. **SIGNATURE:** Sign and date. Personal representative should print name and indicate relationship to the patient. Documentation may be required to prove authority to sign on behalf of the patient.
7. **EXPIRATION:** If no date or event is given, authorization will expire 180 days from days signed.

To submit your request or to send records we requested, please send your completed form via fax or mail. Please visit our website www.midvalleygi.com for additional copies of this form or for more information.

Mid Valley Gastroenterology

3521 N Samaritan Dr., Suite 101
Corvallis, OR 97330

Phone: 541-768-6119
Hours: 8 a.m. to 4:30 p.m.
Fax: 541-768-6120

To request Radiology Images ONLY (x-rays, MRI's, CT, Ultrasound etc.) please send requests to:

Samaritan Film Library
Phone: 541-768-5077 or 5078
Fax: 541-768-5018