AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

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

1. **PATIENT INFORMATION**

PRINT Patient Name: ____
Birth Date (mm/dd/yyyy): ____________________________________
Previous Name(s): ____
Address: ____
City: __________________________State: ______Zip: _____________
Phone #: (_____) ____
Email: ____

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.**
- ✔ **This authorization will expire 36 months from the date I signed this form unless another date or event is specified here: ________________________Date (mm/dd/year)**

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.
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.

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