SOUTHERN COOS
Hospital & Health Center
900 11th St. SE ~ Bandon, OR 97411
(541) 347-2426

Authorization for Release of Protected Health Information

Patient Name:_____ Medical Record # _____

Telephone #:_____ Birthdate:_____

I authorize Southern Coos Health District to: ❑ Release/Disclose to: ❑ Obtain From:

_____

Facility/Agency *Phone #* *Fax #*

_____

Street Address *City/State/Zip Code*

Purpose For Disclosure:

❑ Medical ❑ Legal ❑ Insurance ❑ Personal ❑ Other_____

Check Information to be Released:

- ❑ All Medical Records (limited to 2 years unless otherwise specified)
- ❑ Discharge Summary
- ❑ History & Physical Exam
- ❑ Procedure Note
- ❑ Radiology Report
- ☐ Radiology Film
- ☐ Emergency Room Report
- ❑ EKG, Diagnostic Study Report
- ❑ Pathology Report
- ❑ Laboratory Report
- ❑ Physical /Occupational/Speech Therapy Record
- ❑ Other _____

Specific Dates of Treatment _____

Patient Authorization To Release Medical Information

Restrictions/Duration/Rights

- I authorize the release of the specified information from my medical records.
- I understand that if the person(s) or entity(ies) that receives the information is not a health care service provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.
- I understand that this authorization includes records or health information concerning alcohol/drug abuse, counseling, HIV testing, HIV results and/or AIDS information and does apply to drugs that could potentially be used to treat HIV/AIDS, drug/alcohol and Mental Health.
- I understand that I may be charged for copying costs.
- I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.
- Refusal to sign this authorization will not condition treatment, payment, enrollment or eligibility for benefits.
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- I understand that this authorization will expire on _____ or six (6) months from the date signed below.
- I have received a copy of this authorization.

_____

Signature of patient or person authorized by law to sign for patient *Relationship to Patient* *Date*

_____

Southern Coos Health District Employee Signature *Date* *Prepared By* *Date*

FOR HOSPITAL USE ONLY
ID CHECKED _____ FEE EXPLAINED _____ ❑ Mail ❑ Pick Up

Patient ID Label