Authorization for Release of Protected Health Information

SOUTHERN COOS HOSPITAL & HEALTH CENTER

900 11th St. SE • Bandon, OR 97411 (541) 347-2426

FAX for Incoming Records: (541) 347-3923

EMAIL: medicalrecords@southerncoos.org

Patient Name:_____ Medical Record # _____

Telephone #:_____ Birthdate:_____

☐I Authorize Information to be ***Released/Disclosed to***: ☐I Authorize Information to be ***Obtained From***:

_____

Facility/Agency *Phone #* *Fax #*

_____

Street Address *City/State/Zip Code*

Purpose For Disclosure:

❑ Medical ❑ Legal ❑ Insurance ❑ Personal ❑ Other:_____

❑ Transfer of Care from Primary Care Physician

Delivery Method

❑ Pick Up
❑ Mail
❑ Fax

Check Information to be Released:

❑ All Medical Records ❑ Last 2 years ONLY

❑ 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: to

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, Genetic Testing, 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. _____ **Initial**
- 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*

ID CHECKED: ☐

FEE EXPLAINED: ☐

FOR HOSPITAL USE ONLY

LOGGED IN EHR: MRN: RELEASED BY:

If you will be mailing records to our facility please use the following address:

Southern Coos Hospital Health Center
Attn: Medical Records Department
900 11th St SE
Bandon, OR 97411

Patient ID Label