Southern Coos Hospital & Health Center
900 11th Street, SE
Bandon, OR 97411

Phone: (541) 347-2426
Fax: (541) 347-7324
medicalrecords@southerncoos.org

Authorization for Use and Disclosure of Health Information

Where are the records being released from?

Facility Name: **Southern Coos Hospital & Health Center**

Address: **900 11th St SE** City: **Bandon** State: **Oregon** Zip: **97411**

SECURE Email: **medicalrecords@southerncoos.org**

Phone: **541-347-2426** Fax: **541-347-7324**

Patient Information

Name: DOB:

Email:

Address: City: State: Zip:

Phone: Fax:

Records being released to:

Name:

Address: City: State: Zip:

Phone: Fax:

What would you like released? Check all that apply.

- ☐ Medical Records last 2 yrs (industry standard)
- ☐ Office/Clinic Notes
- ☐ Operative Reports
- ☐ ED / Inpatient Visit
- ☐ Lab/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ All Records
- ☐ Other: Dates: to

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- ☐ Drug/alcohol diagnosis, treatment, or referral Info
- ☐ Genetic Testing Information
- ☐ AIDS/HIV Information
- ☐ Mental Health Information

Purpose of Disclosure:

- ☐ Personal
- ☐ Litigation/Legal
- ☐ Insurance
- ☐ Continuation of Care
- ☐ Transfer to New Physician

Patient's Signature

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time, by sending a written authorization to: Southern Coos Hospital & Health Center, c/o Medical Records, 900 11th Street, SE, Bandon, OR 97411. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. This authorization will expire in 6 months from the date sign.

Patient's Signature: Date:

Relationship to Patient: