

Asher Community Health Center

P.O. Box 307 Fossil OR 97830

Telephone: (541) 763-2725 • Fax: (541) 763-2850 • TTY: 1 (800) 735-2900

Authorization to Use and Release Protected Health Information

*ALL sections of this form **MUST** be completed or the authorization will not be accepted.*

I authorize the following facility, _____
Name of facility releasing records

Address of facility

Telephone # of facility

FAX # of facility

to receive and disclose a copy of the specific health information described below regarding:

Name of patient

Date of birth

**SEND TO: Asher Community Health Center
712 Jay Street
PO Box 307
Fossil, Oregon 97830**

541-763-2725
Telephone # of facility

541-763-2850
FAX # of facility

The information to be released shall consist of:

- All health information
- Discharge Summary
- Treatment plan/progress
- Progress notes
- Medication administration
- Other, specify: _____
- Medication Orders
- Assessment
- UA results
- Labs
- Immunizations

The release is for the following:

- Emergency contact
- Disability
- School entry
- Other, specify: _____
- Continued care
- Family/friend/self
- Legal

