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 regarding:	a copy of the specific health information described below
Name of patient	Date of birth
, 1	Asher Community Health Center 12 Jay Street PO Box 307 Fossil, Oregon 97830
541-763-2725 Telephone # of facility	541-763-2850 FAX # of facility
The information to be rele	used shall consist of:
 () All health information () Discharge Summary () Treatment plan/progre () Progress notes () Medication administra () Other, specify: 	() Labs
The release is for the follo	ving:
() Emergency contact() Disability() School entry() Other, specify:	() Continued care () Family/friend/self () Legal

The information is to be released by:	
 () All forms of communication (verbal, written, electronic, and other) () Verbal only () Other, specify: 	
My initials below authorize the inclusion of the following information as part of this authorized release of records:	
HIV/AIDS informationMental Health information	
Genetic testing information	
Drug/alcohol diagnosis, treatment, or referral information	
I understand I have the right to revoke this authorization, at any time, provided I do so in writing and provided it is directed to the facility responsible for completing the release of information detailed in this document. If I choose to revoke this authorization, it will no longer be used for the reasons covered by this authorization. I understand that disclosures made prior to revoking this authorization cannot be rescinded.	
This authorization becomes effective on the date below, and will expire one year from date below or the date I specify Specific date	
I have reviewed and understand this authorization. If the information released contains alcohol and chemical dependency diagnosis and/or treatment records, the records are further protected by federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit further disclosure of this information unless I expressly permit the disclosure in writing or as otherwise permitted by 42 CFR, Part 2. A general release of medical or other information is NOT sufficient. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.	
Patient signature Date	
Patient representative signature Date	

Form BC