# (*) ROI Horizon

## Horizon Medical Release of Information/Records

1957 Thompson Road
Suite E
Coos Bay, OR 97420
(541)236-2778
info@horizonmedLLC.com

Important: Please read all instructions and information before completing and signing the form.
An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified below

Please type or print as clearly and completely as possible.

**Include your full and complete LEGAL name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information.**

**All these items are used to identify your health record/information and to make certain that only your information is sent. If you information does not match the facility, records may fail to be released.**

## 1) PATIENT INFORMATION

First Name: _____

First, Middle AND Last Name: * _____

Patient Date of Birth: * _____

Previous Name(s): * _____

Home Address: * _____

Mailing Address (if different) _____

City: * _____

State: *

Zip: *

Daytime Phone: *

Email Address (optional):

Medical Record/Patient ID Number
(optional)

**Release for Person**
**to participate and obtain health care information (such as parents, family, caregiver, etc.)**
**I give permission for my medical care and records to be released/discussed with:**

Last Name:

This person can be reached at:

Daytime Phone:

Email Address (optional)

**Records Request: from a facility/organization**
**I am requesting health information be released FROM at least one of the following:**

Organization(s) Name: *

Address: *

**Receiving Facility:**
**I am requesting that health information may be disclosed and be sent to:**

**Organization(s):**
**Horizon Medical, LLC including**
**Lori Shott, FNP-C**
**1957 Thompson Road, Suite E**
**Coos Bay, OR 97420**
**(541)236-2778**
**info@horizonmedllc.com (encrypted secure email)**

For the purpose of: Healthcare coordination Other:

Information to be released
IMPORTANT: indicate only the information that you are authorizing to be released.

- ☐ All Records
- ☐ Most recent 5 year history
- ☐ Laboratory Reports
- ☐ Emergency/Urgent Care records
- ☐ Pathology Reports
- ☐ Diagnostics and Imaging reports/records
- ☐ Clinician Office/Chart Notes
- ☐ Dental Records

Specific Dates/Years of treatment:

- ☐ All Records/Timeframes
- ☐ Last 5 years
- ☐ Specific timeframe specified in OTHER below:

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

- ☐ HIV/AIDS related records
- ☐ Genetic Testing Information
- ☐ Mental Health/Psychiatric Care Records
- ☐ Alcohol and Drug Records/Treatment

**** Health information includes written, photographic/imaging and oral information****

**My signature indicates that I authorize the disclosure of the above information and understand the following:**

**I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or eligibility for healthcare or benefits.**
**I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request/release.**
**I understand this change will not affect information that has already been shared.**
**I understand that federal and state laws protect my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that consent is not required for uses and disclosures for Treatment, Payment, and Health Care Operations. I understand they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission specified above or otherwise permitted by law.**

This consent will end 180 days from the date the form is signed unless earlier date is noted below:

**SIGNATURE** *

Printed Name *

Relationship to Patient

☐ Patient/Self ☐ Legal Guardian/Parent of Named Patient ☐ Healthcare Legal POA

Today's Date: *