Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

Authorization for Release of Protected Health Information

Holmes Family Care is committed to protecting the privacy of information about you and your health. This means that in many cases, we must obtain you authorization in order to disclose protected health information about you. Please read the information below carefully before signing this form.

Patient Name: _____ DOB: _____ Phone: _____

Records request from:

Name of Facility: _____

Adress: _____

Phone: _____ Fax: _____

Records to use or disclose to:

Holmes Family Care Phone: 541-672-7718 Fax: 541-315-7125
2564 NW Edenbower BLVD Ste 126 Roseburg, OR. 97471

_____ I authorize the release of my compete medical records. This authorization for release of information covers the period of health care from: Start Date: _____ to _____

Please initial beside the options below to authorize the release of sensitive information pertaining to:

_____ Mental Health
_____ Drugs or Alcohol
_____ Genetic Testing
_____ HIV/AIDS/other infectious diseases

This information may be used by the person I authorize to receive this information for medical treatment or consultations, billing, or claims payment, or other purposes as I may direct.

- **I understand that this authorization is voluntary, and that I may results to sign it.**
- **I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**
- **I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I have the right to receive a copy of this authorization.**
- **I understand that I have the right to inspect or copy the information to be disclosed.**
- **I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on the authorization.**

By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Representative

_____
Printed Name of Patient or Representative Date: