

**PO Box 207 Medford, Oregon 97501**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize OREGON INTERNAL MEDICINE to release my records to:

Name / Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unless you state otherwise by marking one or both boxes below,** this authorization **includes** the release of records which may include (i) **HIV/AIDS** information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and you affirmatively waive any protections from disclosure that might otherwise apply. **HIV/AIDS** information is defined to include information that a patient has had an HIV test or has been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by the law, the release of **HIV/AIDS** information and/or **privileged mental health communication** can be authorized only by the patient or an individual legally authorized to make a living patient’s healthcare decisions, including a legal guardian, healthcare agent, or parent of a minor.

\_\_\_\_\_ I object to the release of HIV/AIDS information

\_\_\_\_\_ I object to the release of any privileged mental health communications

I understand that my/the patient’s treatment at Oregon Internal Medicine will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. Revoke by submitting a written request to Oregon Internal Medicine identified above.

This authorization for the release of protected health information shall remain in effect for 180 days from the date I signed the authorization.

By signing this authorization, you affirmatively represent that: (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his/her healthcare decisions, including the release of medical records. You understand the potential that medical records disclosed in whatever form and/or means provided may be subject to re-disclosure by the recipient and may no longer be subject to the protections under the federal privacy laws and regulations. You further understand that you may receive electronic health information that may not be encrypted or password protected and that you are responsible for taking precautions to protect and store the data in a secure manner. By choosing to receive your health information electronically, you acknowledge and accept the risk of doing so. You hereby release Oregon Internal Medicine and their agents / employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and / re-disclosure of medical records and information you have authorized above.

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Signature of Patient or Legally Authorized Representative Signature Date