



# Authorization to Release and Receive Protected Health Information

PO Box 3300 La Pine, OR 97739 Phone: 541-536-3435 Fax: 541-536-8047

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ LCHC PCP: \_\_\_\_\_

### I authorize: (Person/Entity Releasing your PHI)

### To Disclose to: (Person/Entity Receiving your PHI)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

### Reason for Records Release:

Continuity of Care  Insurance  Legal  FMLA/Disability  Return to Work  Other \_\_\_\_\_

Chart Notes from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Immunization Records from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Lab Results from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Medication List from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Radiology Report from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Pathology Report from (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

Genetic Testing from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

HIV/AIDS Records/Results from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

STD Records/Results from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

Mental Health Records from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

Behavioral Health Records from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

Drug/Alcohol Records from \_\_\_\_\_ to \_\_\_\_\_ Signature \_\_\_\_\_

### Records Release Format:

MYCHART – Free

Paper

Electronic

### Delivery Method:

MYCHART (MYCHART.OCHIN.ORG)  Pick up in person

Mail to address above

Fax to number above

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 1 year from the date of signing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. I understand that La Pine Community Health Center will provide this information within 30 days from the receipt of the completed request and that a \$10.00 minimum fee for preparing and furnishing 6 pages or more will be charged for all paper copies of records according to federal law.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

