



Medical Record Release Authorization

Blue Mountain Hospital District

170 Ford Road

John Day, Oregon 97845

Phone: 541-575-1311

Medical Records Fax: 541-575-3821

Patient Name _____ Maiden Name _____

Date of Birth _____ Home Phone _____ Cell/Work _____

Address _____ City/State/Zip _____

Email Address: _____

A) I hereby authorize records FROM:

Name Blue Mountain Hospital

Address 170 Ford Rd.

City/State/Zip John Day, Oregon 97845

Phone# 541-575-1311 Fax# 541-575-3821

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____ FAX# _____

C) For the purpose of:

- Litigation
- Insurance
- Self/Personal Copy
- Continuity of Care
- Disability/SSI
- Work Comp
- Other
- Transfer of Care (Permanently Leaving)

Date Range _____ to _____	
<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Cardiology/EKG Reports
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Path Reports
<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Radiology/XRay/MRI Reports
<input type="checkbox"/> Other _____	<input type="checkbox"/> Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

HIV/AIDS Testing/Treatment Mental Health Genetic Testing Drug/Alcohol/Substance

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date)

(Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

Date Fulfilled: _____

Staff Initials: _____