Blue Mountain Hospital District
170 Ford Road, John Day, OR 97845
BlueMountainHospital.org

Blue Mountain Hospital District Release of Information Authorization

*Please allow 5 business days to process requests

Patient

Patient Name: ______________________________ DOB: __________

Address: ______________ City: ____________ State: ____ Zip: ________ Phone: __________

From/To

Information to be released FROM:	Information to be released TO:
Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
Phone: __________ Fax: __________	Phone: __________ Fax: __________

Purpose

Purpose for which disclosure is to be made (mark all that apply):

____ Insurance ____ Legal ____ School/Job ____SS/Disability

____ Self ____Other (specify):______________________________

Information to be Disclosed

Please mark all that apply:

Date Range: ______________ TO ______________

____ Office Notes

____ Immunizations ____ Operative Notes

____ Radiology ____ Lab/Pathology

____ ER Notes ____ Minimum Necessary

____ Cardiology/EKG ____ All (2 yrs)

Specially Protected Information

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

This information will only be disclosed if you initial the spaces provided. Under NO circumstances do we release this information without your consent

Delivery Method

How would you like your records sent?

____ Mailed to you ____ Fax to your PCP

____ Pick up in office (date/time):_______ ____ Pick up in office by another person (name):____________________

Notices

1. I understand that this authorization is valid for any information I request within the time frame before expiration
2. I understand that I have the right to withdraw this authorization at any time in writing. The revocation must be provided to Blue Mountain Hospital District HIM/Medical Records Department
3. I understand that this authorization is voluntary and I can refuse to sign it; I do not need to sign to ensure treatment
4. I understand that any disclosure of information carries a risk of unauthorized disclosure of my health information
5. If I have questions about the disclosure of my health information I can contact medical records
6. I understand that my health information may include records related to mental health, STI/STD treatment/testing, genetic testing and drug/alcohol/substance history and/or abuse. I understand this

Signature

I have read this authorization, and I understand it

______________________________ ______________ __________
Signature of patient or personal respresentative Relationship Date

This release will expire in 1 year unless specified otherwise here: __________________

*If you are the patient representative you may be required to provide appropriate documentation to demonstrate the authority to act on behalf of the patient (i.e. Medical POA, Death Cert., Court Order).

For HIM Staff Only | MRN:__________ Date Recv'd:__________Records Sent By:__________ Date: ________