River Road Medical Group
Physicians and Surgeons Family Group
890 River Road
Eugene, OR 97404
Ph 541-688-0674 – Fax 541-688-5378
www.riverroadmedical.com

AUTHORIZATION TO USE/ DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____

I authorize:

_____

_____

(Please include name, address, phone # and or Fax #, in order to process)

to use and disclose a copy of the specific health and medical information described below

consisting of (type of information to be released):

____ All Medical Records (Records released will be limited to last 2 years of information unless otherwise indicated)

____ Hospital Records/Consultations

____ Motor Vehicle Accident Records

____ Worker's Comp Injury Records

____ Other_____

Must be initialed to be included:

____ HIV/AIDS related records

____ Psychotherapy records

____ Genetic Testing Information

____ Drug/alcohol diagnosis, referral, or treatment (Federal regulation 42CFR, Part 2 requires a description of info to be disclosed) See Restriction box if applicable.

to: (please include name, address, phone#, fax#)

_____

_____

for the purpose of:
☐ Medical Care ☐ Transfer of Care ☐ Relocating ☐ Legal ☐Billing ☐Other

Please indicate the last time you were seen at the requested office in order to better locate your records:
Present – 2 years 3-5 years 6-10 years Over 10 years
If we are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

(1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
(2) You may inspect a copy of the protected health information to be used or disclosed;
(3) You may refuse to sign this Authorization; and
(4) We must provide you with a copy of this signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed information in reliance on this Authorization,
Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of the signing or shall remain in effect for the period reasonably needed to complete the request.
I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient or Patient Representative Signature: _____

Description of Representative's Authority: _____

Date: _____

Restrictions: This authorization is limited to the following time period and/ treatments: _____**(initials)**