

**AUTHORIZATION TO RELEASE AND/OR  
RECEIVE PROTECTED HEALTH INFORMATION**

www.mosaicmedical.org Phone: 541-383-3005

**I hereby authorize:** (Person or entity that is releasing your information on this side)

**To disclose to:** (Person or entity that is receiving your information on this side)

NAME OF SENDING PERSON/ORGANIZATION \_\_\_\_\_

NAME OF RECEIVING PERSON/ORGANIZATION \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY STATE ZIP CODE \_\_\_\_\_

CITY STATE ZIP CODE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

**Records and information pertaining to:**

FULL NAME OF PATIENT \_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_

MEDICAL RECORD NUMBER \_\_\_\_\_

DAYTIME PHONE NUMBER \_\_\_\_\_

**Distribution**

**Type:**

- Paper
- Verbal
- Electronic
- Exchange between both parties above

**Method:**

- Fax Number: \_\_\_\_\_
- Mail to address above
- Testimony/Deposition
- Pickup
- Telephone

**The released information will be used for the following purpose(s):**

- Transfer of Care     Insurance     Legal/Attorney     Worker's Compensation     Other/Continuity of care/Personal \_\_\_\_\_

**CHART NOTES** From: \_\_\_\_\_ To: \_\_\_\_\_

**PATHOLOGY REPORTS** Date(s): \_\_\_\_\_ Name/Type of Test(s): \_\_\_\_\_

**LABORATORY RESULTS** Date(s): \_\_\_\_\_ Name/Type of Test(s): \_\_\_\_\_

**X-RAY REPORTS** Exam(s)/Date(s): \_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand that initialing in the applicable space next to the type of information authorizes the release of that information.

\_\_\_\_\_  **GENETIC TESTING INFORMATION** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

\_\_\_\_\_  **HIV/AIDS RECORDS & RESULTS** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

\_\_\_\_\_  **SEXUALLY-TRANSMITTED DISEASE** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

\_\_\_\_\_  **MENTAL HEALTH** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

\_\_\_\_\_  **BEHAVIORAL HEALTH** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

\_\_\_\_\_  **DRUG/ALCOHOL TREATMENT** From: \_\_\_\_\_ To: \_\_\_\_\_  Chart Notes  Other (Specify): \_\_\_\_\_  
INITIAL HERE

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier in writing, this consent will expire 6 months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. 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. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization. If the individual completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for services.

By signing below, I acknowledge that this document was given to me in a language I understand either in writing or as read to me in its entirety.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
INDICATE RELATIONSHIP

\_\_\_\_\_  
DATE