

NEW PATIENT—Authorization to Release Protected Health Information

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

Mosaic Medical – Medical Records Department
 600 SW Columbia Street, Suite 6210
 Bend, OR 97702

 STREET ADDRESS

Distribution:

- Fax # 541-383-1883
- Mail to address above

 CITY STATE ZIP CODE

 TELEPHONE NUMBER

Records and information pertaining to:

 FULL NAME OF PATIENT

 DATE OF BIRTH (MM/DD/YYYY)

 MEDICAL RECORD NUMBER

 DAYTIME PHONE NUMBER

The released information will be used for the following purpose:

Transfer of Care

ACTIVE PROBLEM/MED LIST

ALL PATHOLOGY

MOST RECENT HOSPITAL RECORDS

LAST 3 NOTES - PROGRESS NOTES

ALL IMAGING

OTHER: _____

LAST 12 MONTHS - LABS

MOST RECENT HEART RELATED TESTING

THESE FORMS: WITHIN LAST YEAR

LAST 3 NOTES - CONSULT NOTES

ALL PROCEDURES

POWER OF ATTORNEY LIVING WILL

POLST LAST NARCOTICS CONTRACT

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.

Please provide the **LAST TWO YEARS** of the following records if initialed by the patient

 INITIAL HERE **MENTAL HEALTH RECORDS**

 INITIAL HERE **BEHAVIORAL HEALTH RECORDS**

 INITIAL HERE **GENETIC TESTING INFORMATION**

 INITIAL HERE **HIV/AIDS RECORDS & RESULTS**

 INITIAL HERE **SEXUALLY-TRANSMITTED DISEASE**

 INITIAL HERE **DRUG/ALCOHOL TREATMENT**

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 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