**Request For and Authorization to Release Medical Records or Health Information**


1525 Echo Hollow Rd, Suite A
Eugene, Oregon 97401
Phone: (541) 607-1430
Fax: (541) 607-1429

## PATIENT INFORMATION

Patient Name:_____Today's Date: _____

Date of Birth :_____ Phone number:_____

I authorize the Bethel Health Center to leave a message on my voicemail: ☐Yes ☐No

## INFORMATION TO BE RELEASED FROM:

I authorize the Bethel Health Center to obtain my health information for the purpose of coordinating care from the following:

Primary Care Physician: _____ Specialist: _____

Therapist: _____ Other: _____

The authorization for the release and disclosure of medical information applies to: (please initial)

_____Drug Abuse _____ Alcoholism _____ HIV/AIDS _____ Mental Health

## INFORMATION TO BE RELEASED TO: (Please initial all that apply)

I authorize the Bethel Health Center to discuss/share protected health information about me to:

| Release to: | Name | Medical Records | Lab results | Financial / Billing | Appt info | Mental Health | All |
|---|---|---|---|---|---|---|---|
| School | | | | | | | |
| Physician | | | | | | | |
| Therapist | | | | | | | |
| Other* (A) | | | | | | | |
| Other* (B) | | | | | | | |

*Other Family/Guardian/Friend relationship to you: (A) _____ (B) _____

## MY RIGHTS/MY AUTHORIZATION

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that I do not have to sign this form in order to assure treatment or payment.
I understand that I may revoke this authorization at any time by notifying the Bethel Health Center in writing. I understand that such revocation will not have any effect on information already used or disclosed by our office before we receive the intent to revoke the authorization. This authorization will expire one year from the date of my signature.

_____ _____

Patient/Guardian/Legal Representative Signature Date

_____

Relationship to patient