Authorization to Release/Disclose Information

I, _____, DOB: _____,
(Full legal name)
hereby authorize The Oasis Center of the Rogue Valley to release protected health information as indicated below to/from:

Name of Organization or Person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Information to be released: (INITIAL all that apply)

____ Standard Problem List
____ Medication Summary
____ Progress Notes
____ Health History
____ Drug and Alcohol diagnosis/treatment
____ HIV/AIDS Test Results and Treatment
____ Multi-Disciplinary Team Notes
____ Complete Records
____ Immunization Records
____ Letters
____ Laboratory Reports
____ Urine Analysis Results
____ Imaging Reports
____ Mental Health Diagnosis/Treatment
____ Genetic Testing
____ Demographic and Contact Information

Dates of Care to be Released from _____ to _____

I understand the information to be released may include behavior, substance use, and/or mental health care, and HIV test results.

Purpose of Request:
____ Continuity of Care ____ Legal ____ Other:

Many of our patients allow family members such as their spouse, parents, or other to call and request medical or billing information. We are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to a family member or another individual, please indicate their name and relationship below:

I authorize Oasis Center of the Rogue Valley to disclose my medical or billing information to the following individual(s):

Individual's Name: _____ Relationship to Patient: _____

Individual's Name: _____ Relationship to Patient: _____

____ Release of Medical Records ____ Verbal Discussion ____No records sent at this time, please keep in file

OASIS CENTER of the Rogue Valley

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I UNDERSTAND THAT:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
- 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 some of the sensitive information described above. (45 CFR § 164.508 (2) (2) (iii))
- I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization.

To revoke this authorization, send a written statement that you are revoking this authorization to:
Oasis Center of the Rogue Valley/Revoke Authorization P.O. Box 1187, Medford, OR 97501

If I revoke my authorization, the information described above may no longer be used or disclosed for purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. (45 CFR § 164.508 (2) (2) (ii)).

The Oasis Center of the Rogue Valley does not discriminate on the basis of race, color, national origin, sex, age, or disability.

I am not required to sign this authorization. Refusal to sign will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means I will not receive health services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (45 CFR § 164.508 (2) (2) (ii))

This authorization expires in one (1) year after the date signed, unless revoked prior.

_____ _____
Signature of Patient or Legal Representative/Guardian Date

_____ _____
Printed Name of Patient or Legal Representative/Guardian Relationship of Legal Representative/Guardian

_____ _____
Witness Signature Printed Name of Witness