O'Connor Family Medicine Records Release

For (Patient):_________________________________(DOB):___________ **I authorize the use or disclosure of**

	All healthcare information in medical record		
	Information in medical record relating to the following treatment or condition:		
	Information in medical record for the date(s):		
	Other (e.g., X-rays, bills)—specify date(s):		Dates:

FROM:	O'Connor Family Medicine	**TO:**	(Name):
	309 E. Farwell Rd. #204 Spokane, WA 99218 509-385-0600 FAX: 509-466-4798	Address:_______________________________________ City:_________________________State:_____Zip:_________ Phone:____________________ Fax:____________________	

for the following reason(s) (check all that apply):

	Continuing medical care		Personal use		Other (please describe):

See the Format Consent Form IF this release is for personal use, or the person releasing the records is the intended recipient.

including information regarding testing/diagnosis/treatment of the following, **except anything indicated below:**

Do not release the following marked items:			HIV/AIDS		Sexually Transmitted Diseases
	Mental Health or Illness		Drug and/or Alcohol Abuse		Reproductive care

This authorization expires in 90 days unless indicated below:

	Expires on (date):		Expires when the following event occurs:

My rights:

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

- to receive research-related treatment in connection with research studies **or**
- to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by O'Connor Family Medicine in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form—a form is available from O'Connor Family Medicine or
- Write a letter to O'Connor Family Medicine.

I also understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

____

Patient or legally authorized individual signature Date

____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, Power of Attorney, etc.)

____

Minor patient's signature, if applicable Date

A minor patient's signature is required for disclosure IF

- The minor is age 14 or older for information related to reproductive care, sexually transmitted diseases, and HIV/AIDS
- The minor is age 13 or older for information related to drug and/or alcohol abuse and mental health or illness