**O’Connor Family Medicine Records Request**

**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:**  | (Name): | **TO:**  | O’Connor Family Medicine |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 309 E. Farwell Rd. #204Spokane, WA 99218 509-385-0600 FAX: 509-466-4798 |
|

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.

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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