



<b>WCHC Office Use Only</b>	
MRN:	_____
Date:	_____
Staff Initials:	_____
Requesting WCHC Provider:	_____

# Authorization to Release Medical Records

**Send Records / Record Requests / Revocation Requests to** ⇒ Waterfall Community Health Center – Attn: Health Information Services 1890 Waite Street, Suite 1, North Bend, Oregon 97459-1229 • 541-756-6232 • F 541-756-6234

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip Code

### I Authorize My Health Information to Be:

Sent to:  
 Requested from:  I don't need records at this time.

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_

My health information:  MAY or  MAY NOT be faxed.  
 MAY or  MAY NOT be securely emailed.

### Purpose of Release:

Changing Physician/Clinic\*  
 Personal Use\*\*  
 Legal  
 Other: \_\_\_\_\_

\*Records sent to outside physicians/clinics are provided free of charge.  
 \*\*There is a copy charge of \$0.25 per page for any personal request for medical records. Please make checks payable to: Waterfall Health Clinic. Your request will be processed within 30 days.

### Indicate Type of Information to Be Released Below:

<input type="checkbox"/> <b>General Medical Records</b> excluding protected records. Copies of medical records will be limited to two (2) years of information, <b>FROM THE LAST DATE SEEN</b> including progress notes, lab and x-ray reports.	<b>-OR-</b>	<input type="checkbox"/> <b>Specific Information Only:</b> <input type="checkbox"/> All Medical Records Specify Date(s): _____ <input type="checkbox"/> Medications Specify Type/Date: _____ <input type="checkbox"/> Lab, Pathology, EKG <input type="checkbox"/> X-ray Reports <input type="checkbox"/> Immunizations Only <input type="checkbox"/> Other Please Specify: _____
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### Protected or Sensitive Information:

I understand that certain information cannot be released without specific authorization as required by State/Federal law. By INITIALING, I authorize the release of the following protected or sensitive information. **Patients 14+ must provide initial.**

\_\_\_\_\_ (initial) DRUG & ALCOHOL DIAGNOSIS/TREATMENT  
 \_\_\_\_\_ (initial) ADD/MENTAL HEALTH TREATMENT  
 \_\_\_\_\_ (initial) AIDS/HIV TEST RESULTS including related high risk behavior  
 \_\_\_\_\_ (initial) GENETIC TESTING

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, 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.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

You have the right to revoke this authorization at any time by providing a written request for revocation to Waterfall Health Clinic, Health Information Services Department. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire **180 Days** from the date signed or will expire on the following date, event, or condition: \_\_\_\_\_.

X _____ Signature of Parent or Legally Responsible Person	_____ Print Name   Relationship	X ____/____/____ Date
X _____ Signature of Patient 14+ years – REQUIRED	_____ Print Name	X ____/____/____ Date