NEM Natural Elements Medicine

AUTHORIZATION TO USE/DISCLOSE MEDICAL RECORDS AND MEDICAL INFORMATION

PLEASE ❑ mail or ❑ fax completed form to: Natural Elements Medicine, Attn: Medical Records, 233 Third Ave SW, Albany OR 967321 Tel: 541-791-6537 Fax: 541-203-7360

Patient Name (print): _____ **Date of Birth**: _____

Other names used_____

Current Address: _____Telephone _____

Purpose of Release request:

❑ Continuity of care ❑ Legal ❑ Personal Use ❑ Insurance ❑ Disability ❑ Other _____

Types of General Medical information to be disclosed:

❑ Physician notes and records (limited to 2 years and excludes protected records)
❑ Lab test results - Specify Dates: _____
❑ Imaging reports - Specify Dates :_____
❑ Electrocardiogram reports
❑ Vaccine and Medication Record'
❑ Problem List
❑ Operative records
❑ Health Information Summary
❑ Other records or test results: Specify information dates _____

I authorize the information designated above to be released from:

Facility Name/Person: _____
Address: _____
Tel: _____ Fax: _____

I authorize the information designated above to be released to:
Natural Elements Medicine, Attn: Dr. Zia L. Robles Hernandez, 233 Third Ave SW, Albany OR 967321
Tel: 541-791-6537 Fax: 541-203-7360

Expiration of Authorization: This permission is valid for 90 days from date of authorization OR until __/__/____ unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting Natural Elements Medicine, 233 Third Ave SW, Albany OR 967321 Tel: 541-791-6537. The only exception is when Natural Elements Medicine has already taken action in reliance on the authorization or when authorization was obtained as a condition of obtaining insurance coverage. If signing for a person over 18 years of age, proof of guardianship, power of attorney or executor of estate must be provided.

Disclosure and Authorization signature:

I understand that I do not have to sign this authorization. My refusal will not affect my ability to receive health care services or reimbursement for services except in the circumstance that the health care services are solely for purpose of providing health information to someone else and authorization is necessary to make that disclosure. I understand that once the information is disclosed pursuant to this authoirzation, it may be re-disclosed by the recipient without the knowledge or consent of Natural Elements Medicine or myself. However I also understand that federal of state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

_____

Signature of patient (or legally responsible person) - state relationship to patient Date

This request is made by: ❑ patient ❑ recipient
If disclosing any of the types of information below, additional laws related to information use and disclosure may apply. By initialing, I give my permission for this information to be disclosed.
____Mental Health
____Drug/Alcohol Conditions
____HIV/AIDS
____Genetic information
Release of this information is limited to: ❑ Time period _____ ❑ Treatment dates_____
Initial here to authorize verbal release between those identified in #3 and #4 _____