FOR OFFICE USE ONLY: Clinic:_____DEP____SCND____FXD____UP____RCVD____MRUP____

ACKR Clinic AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Dr. Janice M. Vaughn-Knox, MD
OR License # 12709

2300 Ferry St SW, Suite 1 P.O. Box 1398 Albany, OR. 97321
Phone: 541-981-2620 Fax: 541-730-4147 Email: info@cannakitchenandresearch.com

NEED FOR REVIEW BY: _____Please & Thank you

Dr. David G. Knox, MD
OR License # 12267

Patient Name: _____ D.O.B._____ Last 4 digits of S.S.N._____
Current Address _____City_____State_____Zip_____
Daytime Phone # _____ Cell # _____
Other Names used: _____

I Hereby Authorize Information to be **RELEASED *FROM***: (Releasor)
Name of Facility/Provider:_____
Address: _____
Phone: _____ Fax: _____

Information to be **RELEASED *TO***: (Recipient) ACKR Clinic
Janice M. Vaughn, MD and David Glen Knox, MD
2300 Ferry St SW, Suite 1; P.O. Box 1398
Albany, Or. 97321-0547
PLEASE FAX TO: 541-730-4147

Type of Information to be Released:

____Physical Therapy
____Last 2 years
____Entire Medical Record (all information)
____MRI/X-ray reports/Laboratory reports
☐ Pages documenting the diagnosis of_____
_____
____All hospital records (including admission note, discharge summary and progress notes)
____Emergency and Urgent Care
☒ Other: Last 2 Visits

REASON FOR REQUEST:

☒ Continuing Care
☐ Personal
☐ Benefits
☐ Legal
☐ Moving/relocating
☐ Changing Doctor
☐ Other:_____

Being requested: ☒ At the request of the Patient ☐ At the request of the Recipient

Protected or Sensitive Information:
If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand that this information will be disclosed *if I place my initials* in the applicable space next to the type of information. (**Please initial where applicable**)

☒_____HIV/AIDS information
☒_____Mental health information
☒_____Drug/ Alcohol diagnosis, treatment or referral information
☒_____Genetic testing information

I understand that the information used or disclosed pursuant to the 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 information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

Initial here to authorize Verbal Release between those identified as the Releasor and Recipient: ☒_____

I have the right to revoke this Authorization at any time, provided that I do so in writing and except to the extent that I have already used or disclosed the information in reliance on this Authorization.

This authorization is valid for 90 days from signed date or shall remain in effect until _____unless revoked by the patient orally or in writing at an earlier time.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

I understand that I do not have to sign this authorization. My refusal to sign this authorization 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 the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Signature of Patient (or legal representative):_____ Date: _____

Print Patient's Name or legal representative: _____Relationship:_____