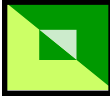
FOR OFFICE USE ONLY: Clinic:_____DEP____SCND____FXD____UP____RCVD____MRUP____



ACKR Clinic AUTHORIZATION TO RELEASE MEDICAL INFORMATION

P.O. Box 1398 Albany, OR. 97321 Phone: 541-981-2620 Fax: 541-730-4147
Email: info.ackr@gmail.com

NEED FOR REVIEW BY: ________________________**Please & Thank yo**

Patient Name: ______________________________________ D.O.B.______________ Last 4 digits of S.S.N.__________
Current Address ____
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***: ACKR Clinic
PLEASE FAX TO: 541-730-4147
P.O. Box 1398 Albany, OR 97321-0547

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)

_X_ **Other: LAST 2 Visits**
____ Emergency and Urgent Care

REASON FOR REQUEST:

- [x] Continuing Care
- [ ] Personal
- [ ] Benefits
- [ ] Legal
- [ ] Moving/relocating
- [ ] Changing Doctor
- [ ] Other:__________________

Being requested: [x] 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 these boxes to prevent delays**

________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.

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.

Print Patient's Name (or legal representative): ______________________________________ Relationship: ___________

Signature of Patient (or legal representative):____ Date: _____________