BENSON HEALTH CLINIC AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

66 Club Rd #160 Eugene, OR 97401 Tel: 541-345-1722 Fax: 541-485-7049

Mailing Address: PO Box 70779 Springfield, OR 97475

Release PHI to: _____

OR Obtain PHI from: _____

Address: _____

Phone: _____ **Fax:** _____

Patient Name: _____ **DOB:** _____

Consisting of:

☐ **Progress/Chart Notes ** last 4**** ☐ **Diagnostic Evaluations** ☐ **Medication List** ☐ **Lab Reports/Genesight Testing**

☐ **Psychological testing** ☐ **Hospital Records** ☐ **Emergency Department and Urgent Care Records**

☐ **Complete medical record–Dates:**_____

☐ **This authorization is limited to the following treatment:** _____

☐ **This authorization is limited to the following time period:**_____

For the purpose of: ☐ **Transfer of Care** ☐ **Coordination of Care/Communication purposes** **OR**

☐ **other:** _____

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 and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS information ___ Mental health information ___ Genetic information
____ Drug/alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if 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.

You may revoke this authorization in writing at any time. If you revoke your authorization the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please send a written statement to Benson Health Clinic, PO Box 70779 Springfield, OR 97475 and state that you are revoking this authorization

I have read this authorization and understand it.

_____ _____ _____

Signature of Patient or Authorized Representative **Relationship** **Date**

Authorized Representative MUST provide legal documentation unless patient is a minor.

This release is valid for 1 year OR until this date: _____ (valid for a minimum of 30 days to allow for processing).