Desert Peaks Health Care

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

This request will not be processed unless the complete name, address, and fax number have been provided.
Federal regulations require a description of how much and what kind of information is to be disclosed.

Patient's Name: _______ Patient's DOB:_____

Please RELEASE information ☐ TO ☐ FROM

_____
Name of Clinic/Provider

_____
City/State/Zip

_____
Phone Number / Fax Number

Please RELEASE information ☐ TO ☐ FROM

_____Desert Peaks Health Care_____
Name of Clinic/Provider

1555 SW Reindeer Ave, Redmond, OR 97756
City/State/Zip

___541.548.4088 / 541.548.3732_____
Phone Number / Fax Number

****IF MORE THAN 50 PAGES, PLEASE MAIL****

By initializing in the spaces below, I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

	Most recent five- year history		All hospital records
	Entire medical record (all information)		Transcribed hospital reports
	Medical records needed for continuity of care		Emergency and urgent care records
	Clinician chart notes & progress notes		Dental Records
	Laboratory reports		Billing statements
	Pathology reports		Mental health treatment plan & summary
	Diagnostic imaging reports		Other

For the disclosed purpose (s) of: _____

If the information to be disclosed contains any of the types of records or information listed below, the laws relating to this information may apply. I understand this information will be disclosed if I place my initials in the applicable space next to the information:

	HIV/AIDS related health information and/or records
	Mental health information and/or records
	Genetic testing information and/or records
	Drug/alcohol diagnosis, treatment, and/or referral information

I understand that:

- The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. 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 disclose.
- I may inspect or have copies of any information to be used or disclosed under this authorization.
- I may revoke this authorization at any time by giving written notice to Desert Peaks Healthcare's Privacy Officer and the information described above may no longer be used or disclosed for the purposes described in this authorization form. Any use or disclosed already made with the patient's authorization cannot be undone.
- Unless revoked earlier, this authorization will expire in 180 days from the date of signing or upon (insert applicable date or event of expiration) _____.

I have read this authorization and I understand it.

Signature of Authorized Representative: _____ Date:_____

Description of Authorized Personal Representative: _____