Journey
Family Medicine

Authorization for Release of Health Information to Journey Family Medicine

I authorize information to be released FROM:

Name of Facility: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please send my records TO:

Journey Family Medicine
995 Willagillespie Rd, Suite 300, Eugene, OR 97401
Phone: 541-228-9700
Fax: 541-228-9800

Purpose of this release:

☐ Medical Care ☐ Transfer of Care ☐ Relocating ☐ Legal ☐ Billing ☐ Request for Personal

☐ Other: _____

Information to be released: Please initial for each information that needs to be released.

	All Medical Records (Records will be to the last 2 years of information unless otherwise indicated)
	HIV/AIDS Information
	Medical Provider Chart Notes
	Mental Health Information
	Imaging Reports
	Genetic Testing Information
	Lab and/or Pathology Reports
	Drug and Alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.
	Other

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.

I hereby consent and authorize Journey Family Medicine to: (Initial each line)

Send/receive a copy of my specific health information to/from person or entity named above: _____

Verbally exchange specific health information with person or organization named above: _____

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. Unless revoked earlier, this Authorization shall remain in effect for 12 months or until age 13, whichever comes first.

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Today's Date: _____

If different than patient, name of legally responsible person: _____

Relationship to Patient: _____

Signature of patient or legally responsible person: _____