Journey
Family Medicine

Authorization to Release Medical Health Information

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:

☐ Consent to communicate only/no records needed ☐ Transfer of Care ☐ Legal ☐ Billing ☐ Personal use

☐ Other: _____

Information to be released:

☐ All Medical Records (Last 2 years of information)
☐ Medical Provider Chart Notes
☐ Imaging Reports
☐ Lab and/or Pathology Reports
☐ Other _____

By initialing below, I authorize release of the following protected or sensitive information.

_____ Mental Health Information
_____ Drug/Alcohol Conditions
_____ HIV/AIDS Information
_____ Genetic Information

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire one year from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

Patient Name: _____ Date of Birth: _____

Name of legally responsible person, if different than patient: _____

Relationship to Patient: _____

Signature of patient or legally responsible person: _____ Today's Date: _____