Wallowa County Healthcare District
601 Medical Parkway; Enterprise, Oregon 97828; Phone: 541-426-3111; Fax: 541-426-1910
- Authorization to Release Medical Information -

Patient Name _____ Date of Birth _____

1. I authorize the following person(s) or entities to receive my protected health information:

□ Myself.
□ Other practitioners and doctors.
□Other:
Name: _____ Address/phone number_____

2. Information I authorize to be released: For the date/date range of:_____

ONLY the following records:

□Lab report	□Emergency Room Report	□EKG studies
□Radiology report (x-ray, CD, etc.)	□Consultation Report	□OTHER:_____
	□Operative Report	_____
□Radiology images (on CD)	□Pathology Report	_____
□Discharge Summary Report	□History and Physical exam report	

For the date/date range of:_____

Purpose for requesting Information: Legal Insurance Personal Continuation of Care Other (please specify on line below)
_____

Disclosure Format (Paper is default if not marked): US Mail – paper format Fax, E-mail (secure format) Email (unsecure format) CD/Flash drive – secure format Other (please specify)_____

3. Information regarding the following will only be released if initialed by the patient:

_____ HIV infection
_____Treatment for alcohol and/or drug abuse
_____ Mental Health
_____Genetic Testing

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-released and is no longer protected by those regulations. Therefore, I release Wallowa County Healthcare District, its employees and physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying in writing the Health Information Management Department knowing that previously disclosed information would not be subject to my revoke request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date

OFFICE STAFF ONLY:
This release is valid until _____, due to regular _____ outpatient visits.

MEDICAL RECORD NUMBER _____