

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Please complete this form to allow Adapt Integrated Health Care to release your health information to other entities.

I authorize:	Adapt Integrated Health Care	621 W. Madrone St. Roseburg, OR 97470
	(Name of Office Releasing Information)	(Address and/or Phone/Fax)
to use and disclose specific health information regarding:		
	(Patient's Full Name)	(Date of Birth)
to:		
	(Name of Office Receiving Information)	(Address and/or Phone/Fax)
for the purpose of (check all that apply):		
<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Phone Conferencing <input type="checkbox"/> Other (specify):		
Please include (check all that apply): <input type="checkbox"/> Chart Notes <input type="checkbox"/> Lab/Path Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> EKG Reports <input type="checkbox"/> Diagnostic Testing <input type="checkbox"/> Immunization Records <input type="checkbox"/> Other, please specify time frame, diagnosis, or specific reports from date patient was last seen:		
If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us: <ul style="list-style-type: none"> 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. <p>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 office. Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing.</p>		
Please initial each statement of consent.		
_____ I consent to the disclosure of my HIV/AIDS information.		
_____ I consent to the disclosure of my mental health information.		
_____ I consent to the disclosure of my genetic testing information.		
_____ I consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.		

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.

 Patient or Guardian / Personal Representative signature (circle one)

 Date

 Printed name of Patient

 Printed name of Signatory and relationship, if not Patient