Choices for Health, PC

RECORDS RELEASE

I, the undersigned, authorize and request a copy of my medical record to be released from:

Gayle Hand, ANP
390 West 12th Ave
Eugene, OR 97401

Office# 541-683-4404

Fax# 541-683-4405

These copies are to be released to:

_____	_____	_____
Provider Name	Provider Address	City/ State/ Zip
_____	_____	
Phone Number	Fax Number	

YOU MAY USE OR DISCLOSE THE FOLLOWING: (Check all that apply):

☐ All health care information in my medical record, including clinical notes, immunization record, preventative care screening (including lab work, mammogram and colonoscopy reports), and the patients problem sheet.

☐ Healthcare information in my medical record relating to following treatment/condition/dates:

_____

☐ Other (please specify)

_____

Additionally YOU MAY USE OR DISCLOSE INFORMATION REGARDING TESTING, DIAGNOSIS, AND TREATMENT FOR (Check all that apply):

☐ HIV (AIDS virus)

☐ Sexually transmitted diseases/reproductive issues

☐ Mental Health/psychiatric conditions

☐ Drug and/or alcohol abuse

I SPECIFICALLY EXCLUDE THE FOLLOWING FROM BEING USED OR DISCLOSED:
Please specify: _____

REASON FOR AUTHORIZATION (Check all that apply)

☐ At my request

☐ Continuing Care

☐ Consultation

☐ Other (please specify)_____

PATIENTS RIGHTS:
My signature below indicates that:
I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment). The recipient of these records cannot transfer them to another party without expressed consent from the patient or authorized guardian. I understand that I may revoke this authorization in writing at any time. If I do so, this will not affect any actions already taken by _____ in accordance with the authorization.
Entity releasing records

NAME OF PATIENT: _____ DOB: _____
First / MI / Last

Former/ Other name (AKA) _____ _____

Name of legal representative_____ Relation to patient: _____

Signature of patient / representative: _____ Date: _____

AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE SIGNED

PLEASE RETURN A COPY OF THIS PATIENT AUTHORIZATION FORM WITH RECORD