Malheur Memorial Health Clinic

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410 Main St./PO Box 1726
Nyssa, OR 97913
Phone: (541) 372-2211
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Authorization for Release of Information

_____ _____ _____
Patient: Please Print Name Date of Birth Soc. Sec. No.

Release of information To/From: MMHC
410 Main St./PO Box 1726, Nyssa, OR 97913
Fax: (541) 372-2583

Release of information To/From: List facility/ provider and full address/phone/fax

From:_____

Address:_____

Phone:_____ Fax:_____

Information to be released: Check the appropriate one.

____ The most recent 2 years (chart notes, labs, x-rays, tests, etc.)
____ All medical records
____ Specific information (specify) _____

Purpose for which disclosure is being made: Check one of the following.

____ Transfer of Care ____ Insurance ____ Doctor/Other Facility ____Coordination of Care
____ Personal ____ Attorney ____ Medical Consultation Only

Patient Authorization: I understand that my records may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. **Note:** Exclude the following Authorization from the records released if they are initialed.

____ Drug/alcohol abuse/treatment and diagnosis
____ Sexually transmitted diseases
____ HIV/AIDS diagnosis/treatment/testing
____ Mental illness or psychiatric diagnosis/treatment

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person/organization may re-disclose it, which time it may no longer be protected under the privacy laws.

Signature: _____ **Date:** _____

Copying fee may be required. This authorization will expire 1 year from the date signed.