Valley Primary Care

171 Lawrence St. Eugene OR 97401
Phone: 541-284-4043 • Fax: 541-284-2099

Authorization of Disclosure of Protected Health Information: Outgoing

I authorize Valley Primary Care
to release my medical information to: _____

Address: _____

Phone: _____

The specific medical records to be released is (please initial):

_____ All Medical Records for the past 2 years including chart notes, labs and imaging reports. I understand that medical records may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health concerns, discussion of HIV testing**. I consent to have the above information released.

_____Specific Medical Records from _____ to _____ or _____ most recent.
Please check medical records requested:

___Chart Notes ___Lab/Pathology Reports
___Imaging/Diagnostic Reports ___Immunization Records

Specially Protected Information (please initial):

_____I consent to disclosure of genetic testing information.

_____I consent to disclosure of my HIV/AIDS information. The purpose of release for

HIV results may be released from _____ to _____.

Expiration Date of Authorization
This authorization is effective for one year or through _____/ _____/ _____ unless revoked or terminated earlier by the patient or the patient's personal representative. (Will need 30 days for processing)

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Privacy Officer at Valley Primary Care 171 Lawrence St. Eugene, OR 97401.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Valley Primary Care discloses it to another party.

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PLEASE NOTE: Medical records sent to another medical provider is of no charge. If the patient requests copies of personal health information maintained by the medical practice, he or she will be charged a flat fee of $5.00 plus $0.10 per page. If the patient requests their records be but on to a disk or USB drive, he or she will be charged a flat fee of $10.00 plus $15.00 for the supplies. Please allow 30 days for processing.

Signature _____

Name of Patient (Print or Type) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient _____

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