Reese Family Practice

Records Release

1755 Coburg Rd. Suite 602 ● Eugene, OR 97401
Office 541-255-3905 ● Medical Records Fax 541-255-3959

1. **PATIENT INFORMATION:**

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CONTACT NO. _____
_____

2. **AUTHORIZATION FOR RELEASE:**

I, _____ hereby authorize _____

to release, disclose, and deliver the medical information described below to:

Reese Family Practice. P.C. Phone: 541-255-3905
1755 Coburg Road Suite 602 Fax: 541-255-3959 or 541-636-4339
Eugene, OR 97401

►ANYTHING OVER 25 PAGES PLEASE MAIL TO THE ADDRESS ABOVE. THANK YOU◄

1. **SPECIFIC AUTHOIZATION:** I specifically authorize the release of **ALL** medical information relating to the above-named patient including but not limited to the following categories protected by the state or federal law: 1.) Substance abuse (drug or alcohol) treatment; 2.) Mental health treatment; and 3.) HIV-AIDS related information, if such information is contained in the records. This authorization includes reports, correspondence, labs, imaging, EKG and any other information in the records, whether generated by the authorized provider or another entity.

2. **RE-DISCLOSURE:** This release does not authorize re-disclosure of medical information beyond the limits of this consent. Recipient of this information is prohibited from using this information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

   This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 and 45 CFR parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3. **VALIDITY:** I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to the revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

   I authorize the release of information as indicated above.

_____ _____ _____
Print Patient Name **Patient Signature** **Date**