The Children's Clinic of Klamath

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____/_____/_____
Please print full name.

Address: _____
Street City State Zip Code

Home/Cell Phone: (_____)_____ Work Phone: (_____)_____

Release Purpose: ❑ Self ❑ Changing provider ❑ Consultation ❑ Legal ❑ Other: _____

(check all appropriate boxes, and provide complete name and address information):

❑ Give records to: ❑ Verbally exchange with: ❑ Request records from:

Name: _____ Phone: (____)_____ FAX: (____)_____

Address: _____
Street City State Zip Code

Email: _____ My medical information: ❑ MAY or ❑ MAY NOT be faxed.
❑ MAY or ❑ MAY NOT be securely emailed.

By initialing spaces below, I specifically authorize the release of the following medical records if such records exist:

_____ Chart notes _____ Laboratory reports _____ ALL medical records
_____ Diagnostic imaging _____ Immunization records ❑ Past 2 years
_____ Other: _____

Records containing the following information require additional consent (items must be initialed to be released):

_____ Mental health and ADD/ADHD diagnosis or treatment information _____ Genetic testing
_____ Drug/alcohol diagnosis, treatment, or referral information _____ HIV/AIDS testing

MY SIGNATURE INDICATES THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand that the information used or disclosed in this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that the person or entity I am authorizing to use and/or disclose information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to:

The Children's Clinic of Klamath
2580 Daggett Avenue
Klamath Falls, OR 97601
541-884-1224 • **FAX 541-884-1637**

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

X_____ _____ X_____/_____/_____
Signature of Patient/Parent/Legal Guardian | Print Name | Relationship to Patient | Date

X_____ _____ X_____/_____/_____
Print Name | Date

Patients 14 years and older – SIGNATURE REQUIRED

MEDICAL RECORDS COPY FEE:
As you may know, we are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patients' rights to confidentiality, as well as to track and report each request. Therefore, in order to fulfill your request, we must ask for an upfront fee before copying. This fee will offset costs associated with copying, tracking, and reporting processes surrounding your request.

There is a flat copy charge of $20.00 for any personal request for medical record copies. Please make checks payable to The Children's Clinic of Klamath. We will process your request when payment is received.

MAXIMUM TIME ALLOWED FOR COPYING MEDICAL RECORDS:

- ♥ Thirty (30) days if chart is maintained at the medical office.
- ♥ Sixty (60) days if chart is maintained off-site in medical records storage facility.

Payment Received: $ _____

Date: / /