AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of Birth:_____ Contact Phone: _____

I authorize the release of my medical information □ To / □ From _____ (Praxis Clinic)
□ To / □ From (physician, office, or person):_____
Address: _____
Phone: _____ Fax#_____
If recipient is a non-Provider person, include an additional identifier, such as Date of Birth: _____
For the following purpose(s): *[describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]* _____.

By ***INITIALING*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist (must have initials in order for records to be released)

___**Send entire medical record** (**all information*) to the above named recipient
OR **For requests beyond most recent history, patient will be charged a reasonable copy/postage fee up to a maximum of $50.00).*
___**Send most recent history at no charge to the above named recipient**
**Includes up to 2 years chart notes, 2 years progress notes and last 3 labs or 50 pages, whichever is greater as well as current medications list, allergy list, active problem list and immunization history.*

____Clinician office chart notes
____Laboratory reports
____Diagnostic imaging reports
____Medical records needed for continuity of care
____Billing statements
____Pathology reports
____Emergency and urgent care records
____Other: _____

(FOR DESERT ORTHOPEDICS ONLY) $10 X-Ray $15 MRI $15 Both MRI/ X-Ray
____Diagnostic Images on Disk (See Front Desk, charges may apply)

The following items must be ***INITIALED*** to be included in the use or disclosure of other health information
_____HIV / AIDS related health information and/or records
_____*Mental health/psychotherapy information and/or records ***must have documented provider approval in chart before release**
_____Genetic testing information and/or records
_____Drug/alcohol/substance abuse information and/or records

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.
- I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.
- This authorization will remain in effect for *one year* from the date of signature unless a stop date is identified.
- I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [insert applicable date or event of expiration]_____.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual