Speciality Behavioral Health Department
Release of Information Form – Instructions

In order for your provider or our Department to release information to a patient or another party on the behalf of a patient, we need to obtain your written permission. The attached form is used for this purpose. If requesting records from our department, we need to have Specialty Behavioral Health Department records (under section 3) ticked off. No records from us can or will be released without this

Please complete this form, and upload it to your portal account or return it to us in person, by mail, or by fax.

Our mailing address is: 444 NW Elks Dr., Corvallis, OR 97330

Our confidential fax number is: 541-768-2353

If a form is completed incorrectly, we will not release the records. Page three answers common questions about filling out this form and page four has an example of what a correctly filled out form looks like.

If you have any further questions about the form, please call us during regular business hours (Monday to Friday from 8am to 5pm, excluding holidays) at 541-754-1288.

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND MEDICAL INFORMATION

Please mail or fax completed form to: Health Information/Release of Records, 444 NW Elks Drive, Corvallis, OR 97330 Phone: 541-768-2368 | Fax: 541-753-1966 | www.corvallisclinic.com

Patient name:______________________________ Other names used: ____________________
Current address:______________________________ Date of birth:______________________________
Daytime phone:________________ Home phone:____________ Last four digits of SSN: ___________

1. Purpose of Release Request

- ❑ Changing doctors
- ❑ Legal/attorney use
- ❑ Self-use
- ❑ Insurance
- ❑ Moving outside the area
- ❑ Doctor consultation/referral
- ❑ Other: Please specify :……………………..

2. Type of General Medical Information to be Released

- ❑ Complete copy of all medical records. This will include radiology and mental health records.
- ❑ Specialty Behavioral Health Department records
- ❑ Physician notes and records (limited to two (2) years of information and mental health and mental health diagnosis)
- ❑ Lab test results. Please specify tests and their dates____________________
- ❑ Imaging reports or CD (X-ray, MRI, etc.) Please specify dates____________
- ❑ Electrocardiogram (ECG/EKG) reports
- ❑ Vaccine and medication record
- ❑ Problem list
- ❑ Operative records (procedures done at The Corvallis Clinic)
- ❑ Health information summary; dates………………………………………………..
- ❑ Billing
- ❑ Other records or test results.

Please specify information and dates:______________________________

By placing my initials on any of the below listed items, I hereby agree to their release:

……… **HIV/AIDS Information**

……… **Genetic Information**

Release of the above information is limited to the following time frame or treatment dates:

……………………………………..…

3. I authorize the information designated above to be released from:

❑ The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility, person, or provider:______________________________
Fax number: ______________________________
Email: ……….……………………………………………………………..
Street address: ______________________________
City/State/Zip:______________________________

4. I authorize the information designated above to be released to:

❑ The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility or person:______________________________
Fax number:…………………………………………………………………
Email : ______________________________
Street address:______________________________
City/State/Zip:______________________________

5. Expiration of Authorization of Release (Required)
This authorization is valid for 90 days from the date of the authorization or until (specify date)___/___/____unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting the HIPAA Privacy Officer, 444 NW Elks Drive, Corvallis, OR 97330, telephone 541-754-1374. The only exception is when The Corvallis Clinic has already acted in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

6. Disclosure & Authorization Signature (Required)
I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that 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 once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of The Corvallis Clinic or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

____
Signature of patient (or legally responsible person)-state relationship to patient **Date**

The following page is an example of what a correctly filled out release would look like if you are requesting records to be released to yourself.

- **Self-use is for if records are being released to an individual i.e., the patient themselves or their family member. The individual records are being released to needs their info put in to section 9**

- **All releases automatically expire in 90 days from signing, unless an alternative date is put under section 10.** ***You cannot write in for it to "never expire". Please write in a date far in the future if you would like it to last as long as possible i.e., 1/1/2050***

- **If the records are to be released to another facility/school/insurance/government entity/law firm/doctor's office, the only info different from the following example will be changes to section 1 (Purpose of Release) and section 9 (who we are releasing records to)**

  - **In those instances, the purpose of release would depend on the situation and would be changing doctors, doctor consultation/referral, legal/attorney use, insurance, moving outside the area, or other (please include a reason if you select other)**

  - **Section 9 needs the info of wherever you would like the records sent to, please fill out as much as possible and include a mailing address or fax number for us to send it over** ***(we cannot email records)***

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND MEDICAL INFORMATION

Please mail or fax completed form to: Health Information/Release of Records, 444 NW Elks Drive, Corvallis, OR 97330 Phone: 541-768-2368 | Fax: 541-753-1966 | www.corvallisclinic.com

Patient name: John Doe Other names used: Jim
Current address: 1234 Street Corvallis, Or 99999 Date of birth: 01/01/01

Daytime phone: 123-456-7890 Home phone: Last four digits of SSN: 0000

1. Purpose of Release Request

- ❑ Changing doctors
- ❑ Legal/attorney use
- x Self-use
- ❑ Insurance
- ❑ Moving outside the area
- ❑ Doctor consultation/referral
- ❑ Other: Please specify :........................

7. Type of General Medical Information to be Released

- ❑ Complete copy of all medical records. This will include radiology and mental health records.
- x Specialty Behavioral Health Department records
- ❑ Physician notes and records (limited to two (2) years of information and mental health and mental health diagnosis)
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- ❑ Problem list
- ❑ Operative records (procedures done at The Corvallis Clinic)
- ❑ Health information summary; dates...
- ❑ Billing
- ❑ Other records or test results.

Please specify information and dates:

By placing my initials on any of the below listed items, I hereby agree to their release:

.... **HIV/AIDS Information**

.... **Genetic Information**

Release of the above information is limited to the following time frame or treatment dates:

....

8. I authorize the information designated above to be released from:

x The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility, person, or provider:
Fax number:
Email: ....
Street address:
City/State/Zip:

9. I authorize the information designated above to be released to:

❑ The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility or person: John Doe
Fax number:…if available…………………………………………………………
Email : john.doe@email.com
Street address: 1234 Street
City/State/Zip: Corvallis, Or 99999

10. Expiration of Authorization of Release (Required)
This authorization is valid for 90 days from the date of the authorization or until (specify date) 9 /9/99 unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting the HIPAA Privacy Officer, 444 NW Elks Drive, Corvallis, OR 97330, telephone 541-754-1374. The only exception is when The Corvallis Clinic has already acted in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

11. Disclosure & Authorization Signature (Required)
I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that 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 once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of The Corvallis Clinic or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

John Doe 1/1/2023

Signature of patient (or legally responsible person)-state relationship to patient **Date** MD1240(0919)