Waterfall Community Health Center

WCHC Office Use Only

MRN: _____

Date: _____

Staff Initials: _____

Requesting WCHC Provider:

_____

AUTHORIZATION FOR MEDICAL/DENTAL RECORDS

Send Records / Record Requests / Revocation Requests to ⇨ Waterfall Community Health Center – Attn: Health Information Services 1890 Waite Street, Suite 1, North Bend, Oregon 97459-1229 •541-756-6232• F 541-756-6234

Patient Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address: _____
Street City State Zip Code

I Authorize My Health Information to Be:

❑ Sent to:
❑ Requested from: ❑ **I don't need records at this time.**

Name: _____

Address: _____

City/State/Zip: _____

Phone: (____)_____ Fax: (____)_____

Email: _____

My health information: ❑ **MAY** or ❑ **MAY NOT** be faxed.
❑ **MAY** or ❑ **MAY NOT** be securely emailed.

Purpose of Release:

❑ Changing Physician/Clinic*
❑ Personal Use**
❑ Legal
❑ Other: _____

*Records sent to outside physicians/clinics are provided free of charge.

**There is a copy charge of $0.25 per page for any personal request for medical records. Please make checks payable to: Waterfall Health Clinic. Your request will be processed within 30 days.

Indicate Type of Information to Be Released Below:

❑ **General Medical/Dental:** Protected records. Copies of medical records will be limited to two (2) years of information, FROM THE LAST DATE SEEN including progress notes, lab and x-ray reports.

–OR–

Specific Information Only:

❑ **All Medical Records**
❑ **All Dental Records**
❑ **Medications**
❑ **Lab, Pathology, EKG**
❑ **X-ray Reports**
❑ **Immunizations Only**
❑ **Other**

Specify Date(s): _____

Specify Type/Date: _____

Please Specify: _____

Protected or Sensitive Information:

I understand that certain information cannot be released without specific authorization as required by State/Federal law. By INITIALING, I authorize the release of the following protected or sensitive information. **Patients 14+ must provide initial.**

_____(initial) DRUG & ALCOHOL DIAGNOSIS/TREATMENT
_____(initial) ADD/MENTAL HEALTH TREATMENT
_____(initial) AIDS/HIV TEST RESULTS including related high risk behavior
_____(initial) GENETIC TESTING

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

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

You have the right to revoke this authorization at any time by providing a written request for revocation to Waterfall Health Clinic, Health Information Services Department. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire *180 Days* from the date signed or will expire on the following date, event, or condition: _____.

X_____ _____ X____/____/____
Signature of Parent or Legally Responsible Person | Print Name | Relationship | Date

X_____ _____ X____/____/____
Signature of Patient 14+ years - REQUIRED | Print Name | Date

Rev. 8/24/2023