Oregon Ear, Nose & Throat Center
541-779-7331

RECEIVE
General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone: _____ SSN: _____

I authorize the custodian of records of: _____
Facility name, telephone, fax number and address if needed

To disclose/release the following information* (check all that apply):

☐ All records
☐ Billing records
☐ Pharmacy/prescription
☐ Laboratory/pathology records
☐ X-Ray/radiology records
☐ Other (describe specifically) _____

* NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send records indicated above to: OREGON EAR, NOSE, AND THROAT CENTER
1170 ROYAL AVENUE, MEDFORD, OR 97501

For the purpose of: _____

(Describe each purpose of disclosure, or state "At the request of the individual" if authorization is initiated by the individual and the individual does not or elects not to provide a statement of purpose.)

This authorization shall expire 365 days from the date of signing and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient's representative Representative's authority to sign for patient
(e.g. parent, guardian, power of attorney for health care)