Mtn. View Family Practice, P.C.
24900 SE Stark St, Suite 205
Gresham, OR 97030
Tel: 503.665.1010 Fax: 503.665.1023

Request for an Individual's Health Information

Last: **First:** **Middle:**

Other Names Used: **Date of Birth:** **SS#:**

Address:

Home Phone: ( ) **Work Phone: ( )**

☐ **I hereby request access to the protected health information in my health record from (date) _____ to (date) _____**

[ ] Entire Health Record
[ ] Most recent Progress Note
[ ] Pathology/Lab Reports
[ ] X-rays Reports
[ ] Immunization Records
[ ] Billing Records
[ ] Other_____

[ ] I will pick up the copies of my records
[ ] Mail copies of my records to the individual noted below :

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Mtn. View Family Practice, P.C. may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.** ***Initial:*** _____
- The information authorized for release also may include protected health information related to mental health***. Initial:*** _____
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released. ***Initial:*** _____
- **HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. ***Initial:*** _____

_____ _____ _____
Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date

FOR OFFICE USE ONLY:

Date Processed: _____ Processed By: _____ Sent via: _____