



MOUNTAIN MEDICAL IMMEDIATE CARE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize _____ to use and disclose personal health

information to Mountain Medical Immediate Care 1302 NE 3rd Street, Bend, OR 97701.

Name of patient: _____

Date of birth : _____

For the purpose of: _____

By initialing the spaces below, I authorize the release of the following medical records:

_____ Entire Medical Record

_____ Pathology Reports

_____ Records for continuity of care

_____ Most recent five years

_____ Laboratory Reports

_____ Billing Statements

_____ Diagnostic Imaging (x-rays)

_____ Other; _____

This authorization is valid for ninety(90) days and may be revoked at any time in writing, except to the extent that action has been taken in reliance thereon. Information may no longer be protected by the Privacy Rule once it is disclosed by the covered entity. This authorization must be dated and signed by the patient or by a person authorized by law to give this authorization. The patient has the right to amend, correct, or restrict the use of medical information. Refusal to sign this authorization in no way affects the patient's treatment.

Signature of Patient or Guardian

Date