Pendleton Primary Care Clinic

1100 Southgate Ste 11
Pendleton, OR 97801
Phone: 541-966-6916 Fax: 541-228-9120

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____

Phone: _____ Address: _____

I hereby authorize Pendleton Primary Care Clinic to (choose one):

- ☐ **use or share my protected health information as follows WITH:**
- ☐ **obtain my protected health information FROM:**

Name of Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorization for the release of information from _____ to _____:

- ☐ All Records
- ☐ Chart Notes
- ☐ Lab Results
- ☐ Hospital Records
- ☐ Radiology Reports
- ☐ Other/Comments: _____

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. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use of 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 of disclosure of this protected health information.

_____ _____ _____

Patient/Representative Name *Signature* *Date*