Kids Clinic
R. D. Jones, MD
691 Murphy Rd, Suite 209
Medford Oregon 97504

RECORD RELEASE

Authorization to Release Protected Health Information

I authorize to release records TO:	**I authorize to release records FROM:**
Name: _____	Kids Clinic
Address: _____	691 Murphy Rd Suite 209
City/State/Zip: _____	Medford OR 97504
Phone: _____	541.772.5548
Fax: _____	541.245.0919

PATIENT INFORMATION

Name: _____ DOB: _____

Consisting of: _____

This information is being used for the purpose of:

_____
(Describe purpose of disclosure)

If the information to be disclosed contains any information related to HIV/AIDS, mental health diagnosis or medication management, genetic testing, drug/alcohol diagnosis, treatment and/or referral information additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed by signing below.

I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. Provider has up to 30 days to release medical records according to Oregon law and the Health Information Privacy Protection Act.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services and or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make the disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please send a written statement to Kids Clinic Office Manager.

I have read and understand this authorization. Unless revoked this expires when records are released.

_____ _____
Signature of patient or representative Date