Klamath Health Partnership Inc.

Klamath Open Door Family Practice
2074 South 6th Street
Klamath Falls, OR 97601
Phone 541- 851-8110
Fax 541- 851-8114

Chiloquin Open Door Family Practice
P.O. Box 695/103 Wasco Avenue
Chiloquin, OR 97624
Phone 541-783-2292
Fax 541- 783-3160

Please fax medical records to 541-885-7386

Patient Name: _____ **DOB:** _____

I authorize: _____

Address_____

Phone Number_____ Fax Number_____

To disclose health information that includes the following: (please **initial** everything that applies)

Chart notes_____ Meds List_____ EKG/Treadmill_____ Immunizations_____ HIV/AIDS_____

Lab Reports_____ Radiology Reports_____ Substance Abuse _____ Mental Health_____

Please disclose the above selected records for: ☐ Last 6 Mo. ☐ Last 1 Yr ☐ Last 2 Yrs ☐ All ☐ Other_____

To: _____

Address_____

Phone Number_____ Fax Number_____

For the purpose of _____

I understand that the authorization to disclose my health information is voluntary. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
The only circumstance in which refusal to sign means you will not receive health care services, is if the health care services represent research related treatment and the authorization is necessary for you to participate.
I understand that I may review and receive a copy of the information described on this form and I am entitled to a copy of this authorization after I sign it.
I understand my medical record may be voluminous and agree to pay all reasonable charges associated with the copy and transfer of this record.
I understand that I may revoke this consent at any time provided that I do so in writing and except to the extent that action has already been taken.
I understand that the health information disclosed may be subject to re-disclosure by the recipient and no longer protected.
I understand that it may take up to 30 days to get the copy of my medical records.
I understand that I may contact the privacy officer if I have questions about disclosure of my health information at 541.851.8110.
ORS.192.521 Health care provider and state health plan charges. A health care provider or state health plan that receives an authorization to disclose protected health information may charge no more than $30.00. Klamath Health Partnership charges $1.00 per page up to $15.00 except for (Lab reports, Medication list or Immunization history)

This consent will expire on: _____ or 180 days from the date of execution.
I give my permission for my medical information to be faxed to the above fax number. **(Initial)** _____

Patient Signature_____ **Date** _____

Patient Representative Signature_____ **Date** _____