MosaicMedical
Quality Care For All

AUTHORIZATION TO RELEASE AND/OR RECEIVE PROTECTED HEALTH INFORMATION

www.mosaicmedical.org Phone: 541-383-3005

I hereby authorize: (Person or entity that is releasing your information on this side)

NAME OF SENDING PERSON/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

To disclose to: (Person or entity that is receiving your information on this side)

NAME OF RECEIVING PERSON/ORGANIZATION

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

Records and information pertaining to:

FULL NAME OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

MEDICAL RECORD NUMBER

DAYTIME PHONE NUMBER

Distribution

Type:
- ☐ Paper
- ☐ Verbal
- ☐ Electronic
- ☐ Exchange between both parties above

Method:
- ☐ **Fax Number:** _____
- ☐ Mail to address above
- ☐ Testimony/Deposition
- ☐ Pickup
- ☐ Telephone

The released information will be used for the following purpose(s):

☐Transfer of Care ☐Insurance ☐Legal/Attorney ☐Worker's Compensation ☐Other/Continuity of care/Personal_____

☐**CHART NOTES** *From:*_____ *To:*_____

☐**PATHOLOGY REPORTS** *Date(s):*_____ *Name/Type of Test(s):*_____

☐**LABORATORY RESULTS** *Date(s):*_____ *Name/Type of Test(s):*_____

☐**X-RAY REPORTS** Exam(s)/Date(s):_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand that initialing in the applicable space next to the type of information authorizes the release of that information.

_____ ☐**GENETIC TESTING INFORMATION** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

_____ ☐**HIV/AIDS RECORDS & RESULTS** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

_____ ☐**SEXUALLY-TRANSMITTED DISEASE** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

_____ ☐**MENTAL HEALTH** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

_____ ☐**BEHAVIORAL HEALTH** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

_____ ☐**DRUG/ALCOHOL TREATMENT** *From:*_____ *To:*_____ ☐Chart Notes ☐Other (Specify): _____
INITIAL HERE

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier in writing, this consent will expire 6 months from the date of signing or shall remain in effect for a period reasonably needed to complete the request. I understand that 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. This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization. If the individual completing this form is the legal guardian, has legal custody of, or has power of attorney for the patient, the legal document indicating authorization must accompany this request. Completion of this form is voluntary. However, refusal to release necessary medical information may affect eligibility for services.

By signing below, I acknowledge that this document was given to me in a language I understand either in writing or as read to me in its entirety.

SIGNATURE INDICATE RELATIONSHIP DATE