NORTH BEND MEDICAL CENTER, INC.
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION
Medical Records Fax# 541-266-4591

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize information to be released

FROM: _____
Name of Facility

_____
PO Box/Street Address

_____
City, State, Zip

Fax#

Please send my records

TO: North Bend Medical Center Att: Pt Access
Name of Facility
1900 Woodland Drive
PO Box/Street Address
Coos Bay, OR 97420
City, State, Zip
Phone# 541-267-5151 Fax# 541-266-4590

PURPOSE OF THIS RELEASE: ☐ ***PICTURE ID CHECKED***

☒ Medical Care ☐ Transfer of Care ☐ Relocating ☐ Legal ☐ Billing ☒ Request of Individual ☐ Other _____

TYPE OF INFORMATION TO BE RELEASED:

☒ All Medical Records

- ❑ Physician Notes
- ❑ X-Ray Reports
- ❑ Lab and/or Pathology Reports
- ❑ Hospital Records/Consultations
- ❑ Physical Therapy Records
- ❑ Worker's Comp Injury Records
- ❑ Other _____

*** Must be initialed to be included in other documents**

____ HIV/AIDS – related records
____ Mental Health / Behavior Health Counseling and/or Treatment information.
____ Genetic Testing Information
____ Drug/alcohol diagnosis, treatment or referral information (Federal regulation, 42CFR Part 2, requires a description of how much and what kind of info is to be disclosed.) If applicable complete restriction box below.

Your health care & payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:
(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.
You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any used or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the attention of Privacy Officer at North Bend Medical Center, Inc. – 1900 Woodland Drive – Coos Bay, OR 97420 that identified the data you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking the Authorization.
The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.
This Authorization will expire on the earlier of _____(date), or 1 year from the date of signing.

Restrictions - Initial & Complete if applicable:

____ This authorization is limited to the following dates of service: From: _____ To:_____

____ This authorization is limited to the following treatment: _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

Patient Name (print) _____ DOB _____ Phone_____

Address _____ City _____St. _____ Zip_____

X_____

Signature of patient or legally responsible person Relationship to Patient Date

I specifically give authorization to FAX my medical information. I understand that risk is involved in faxing records and confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

_____ (initial)