SKY LAKES MEDICAL CENTER
2865 Daggett Avenue : Klamath Falls OR : 97601

KLAMATH ORTHOPEDIC CLINIC
and Sports Medicine
2200 Bryant Williams Drive Suite 1,
Klamath Falls, Oregon 97601 541.884.7746

Authorization To Disclose Protected Health Information

Patient's Medical Record Number

Patient Name: _____ DOB: _____

I authorize: ❑ **Sky Lakes Medical Center or** ❑ **Other Entity** _____
(name of disclosing party)

to use and/or disclosure a copy of the health information described below for the above named patient.

Health Information is to be received or used by:

❑ Patient ❑ Other (please specify) : _____

For the purpose (s) of:

❑ Patient ❑ Other (please specify) : _____

Type and amount of information to be used or disclosed: (check desired items)

❑ Discharge Summary
❑ History and Physical
❑ Laboratory Reports
❑ Diagnostic Imaging Reports & Films (**please specify**)
❑ Cardiac Cath Lab Reports / Films
❑ CT Scan Reports / Films
❑ Mammography Reports / Films
❑ MRI Report / Films
❑ Nuclear Medicine Reports / Films
❑ Ultrasound Reports / Films
❑ X-ray Reports / Films
❑ Emergency Room Record
❑ Clinic Records (Please specify clinic)
❑ Consultation
❑ Operative Report
❑ Pathology Report
❑ Physical / Occupational Therapy
❑ All hospital records
❑ Billing

❑ Other (please specify) _____

For the most recent date of service or time period: _____ to _____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996 ("HIPAA"),45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

If the information to be disclosed contains any types of records or information listed below, additional laws relating to the use or disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the space(s) below.

__ HIV / AIDS information __ Mental Health Information __ Genetic Testing __ Drug / alcohol treatment

I understand that if the recipient of the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand I may refuse to sign this authorization; and need not sign this authorization in order to ensure treatment. I am entitled to a copy of this authorization after I sign it. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the providing organization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient / Legal Representative _____ Relationship _____ Date _____

By signing this form for someone else, you as the parent, guardian, a party acting *in loco parentis*, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

This authorization will expire (insert date or event): _____

If expiration date or event is not specified, this authorization will automatically expire 24 months from the day it was signed.

For Sky Lakes Use Only:

Date received: _____ ❑ Verified identity and authority ❑ Fees explained (if needed)

Records sent by: _____ Date: _____