

GROSKOPP & RYLAND
ROGUE VALLEY PHYSICIANS, P.C..
800 E. Main Street, Medford, OR 97504
(541) 608-7683 Fax (541) 608-7689

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525

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

From: Groskopp & Ryland
800 E Main St
Medford, OR 97504
Phone: 541-608-7683
Fax: 541-608-7689

☐ Kristine Groskopp, DO

☐ Mary Barnum, FNP
☐ Dannielle Byers, FNP

To:

(Name of hospital/ health care provider)

(Address of provider)

To disclose a copy of the medical information for:

(Name of patient)

(Date of Birth)

Social Security Number

Information to be Used or Disclosed

By **initialing** the spaces below, I specifically authorize disclosure of the following medical records, if they exist:

____ Please send entire medical record (if such records exist) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

OR from Date __/__/__ **to** __/__/__ **please send:**

____ Clinician office chart notes

____ Telephone notes

Other _____

____ Laboratory reports

____ Medication list

____ Diagnostic imaging reports

____ External specialist consults

____ Immunization records

____ Hospital and urgent care records

PROTECTED OR SENSITIVE INFORMATION: I UNDERSTAND THAT CERTAIN INFORMATION CANNOT BE RELEASED WITHOUT SPECIFIC AUTHORIZATION AS REQUIRED BY FEDERAL AND/OR STATE REGULATIONS.

BY INITIALING, I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED OR SENSITIVE INFORMATION:

____ HIV/AIDS/STD related records

____ Mental health information

____ Genetic testing information

____ Drug/alcohol diagnosis, treatment or referral information

Expiration Date of Authorization

This authorization is effective for one year unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Groskopp & Ryland. You should contact the Office Manager/Compliance Officer to terminate this authorization. The only exception is when action has already been taken in reliance on the authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

(Date)

(Signature of patient or person authorized by law)

Relationship of Patient Representative to Patient (if signed by other than the Patient)