

**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 <b>FROM:</b> _____ Name of Facility _____ PO Box/Street Address _____ City, State, Zip Fax# _____	Please send my records <b>To:</b> <u>North Bend Medical Center</u> <u>Att: Pt Access</u> Name of Facility <u>1900 Woodland Drive</u> PO Box/Street Address <u>Coos Bay, OR 97420</u> City, State, Zip Phone# 541-267-5151 Fax# 541-266-4590
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**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)

NBMC Form MR 50-113-019 Rev. 08/12