

# Authorization to Release Protected Health Information (PHI)

**Klamath Orthopedic Clinic**  
**2200 Bryant Williams Dr. Suite 1**  
**Klamath Falls, OR 97601**

CHART# \_\_\_\_\_

Patient Name \_\_\_\_\_ Maiden Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell/Work \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

## A) I hereby authorize records FROM:

Name KLAMATH ORTHOPEDIC CLINIC

Address 2200 BRYANT WILLIAMS DR, STE 1

City/State/Zip KLAMATH FALLS, OR 97601

Phone# 541-884-7746 Fax# 541-274-5745

## B) To be released TO:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone# \_\_\_\_\_ FAX# \_\_\_\_\_

## C) For the purpose of:

- |   |  |
|---|--|
| <input type="checkbox"/> Litigation         | <input type="checkbox"/> Disability/SSI                            |
| <input type="checkbox"/> Insurance          | <input type="checkbox"/> Work Comp                                 |
| <input type="checkbox"/> Self/Personal Copy | <input type="checkbox"/> Other                                     |
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Transfer of Care<br>(Permanently Leaving) |

Date Range _____ to _____	
Specified Body Part _____	
<input type="checkbox"/> Physician Office Notes	<input type="checkbox"/> Operative/Procedure Reports
<input type="checkbox"/> Radiology/X-ray/MRI Reports	<input type="checkbox"/> Radiology/X-ray/MRI Images CD*
<input type="checkbox"/> Minimum Necessary	<input type="checkbox"/> Financial Statement/Billing
<input type="checkbox"/> Other _____	
(* only the last 2 years of images will be provided)	

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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 Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization pertains to records for dates on or prior to my signed records request and a new records request is necessary for future records.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative) **\*\*Subject to Fees**

**\*\*PLEASE READ Fee Information:** *Klamath Orthopedic Clinic* contracts with DataFile Technologies to copy and provide all medical records requested from our office. DataFile Technologies reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, DataFile Technologies may transfer a minimal portion of your records as a courtesy.