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GOODFELLOW LAW

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AUTHORIZATION TO DISCLOSE HEALTH AND MEDICAL INFORMATION

Re: ______________________
Date of Birth: __________ _________________
Social Security No.:__________

To Whom It May Concern:

I hereby authorize ____ to disclose specific health and medical information for __________________ **("client")** to the Law Offices of Goodfellow Law, 105 NE 4TH Street, McMinnville, Oregon 97128.

The information will be used on my behalf for the following purpose(s): investigation and litigation (or, "at the request of the client/client's representative").

By initialing the spaces below, I specifically authorize the release of the following personal health information, if such personal health information exists:

______ All hospital records (including nursing records and progress notes)
_______Transcribed hospital reports
_______Medical records needed for continuity of care
_______Most recent five year history
_______Laboratory reports
_______Pathology reports
_______*HIV/AIDS–related records
_______*Genetic testing information
_______Clinician office chart notes
_______Dental records
_______Physical therapy records
_______Emergency and Urgent Care records
_______Billing Statements
_______Diagnostic Imaging
_______*Mental Health information

**Must be initialed to be included in other documents.*
_______Please send the entire medical record (all information) 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.
_______**Drug/Alcohol diagnosis, treatment or referral information: ______________________________.
***Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*
_______This authorization is limited to the following treatment: ___________________________________

____.

This authorization is limited to the following time period of treatment or medical care:_________________
____.

This authorization is limited to workers' compensation claim for injuries of: _________________.
(Date)

_______This Authorization will expire on the earlier of _________________ (date), 180 days from the date of signing, or at the end of the period reasonably needed to complete the authorized disclosure.

You do not need to sign this Authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purposes of providing health information to someone else and the authorization is necessary to make that disclosure. You understand that authorizing the use or disclosure of the information identified above is voluntary. The health care provider will not condition treatment, payment, enrollment or eligibility of benefits on whether you sign this authorization.

Failure or refusal to sign this Authorization may affect whether legal action can be taken on your behalf.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, any ongoing disclosure of specific health and medical information for the purposes outlined above will cease. To revoke this Authorization, send a written statement to Goodfellow Law, 105 NE 4TH Street, McMinnville, Oregon 97128, that identifies the date you signed this Authorization, the recipient of this Authorization [Goodfellow Law], and states that you are revoking this authorization.

I have reviewed and I understand this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

By: ____ Date: _________________________
(client)

-OR-

By: ____ Date: _________________________

Goodfellow & Cottle
Attorneys at Law

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