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_____

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 mailed, faxed, or emailed to:

☐ Patient address as listed above ☐ Physician Office as listed below

☐ Email _____

Physician Name _____

Address_____

City/State/Zip_____

Phone#_____FAX#_____

C) For the purpose of:

_____ Litigation

_____ Insurance

_____ Self/Personal Copy

_____ Continuity of Care

_____ Disability/SSI

_____ Work Comp

_____ Other

_____ Transfer of Care (Permanently Leaving)

Specified Date Range_____ to_____

Specified Body Part _____

☐ Physician Office Notes ☐ Operative/Procedure Reports

☐ Radiology/X-ray/MRI Reports ☐ Radiology/X-ray/MRI Images CD*

☐ Minimum Necessary ☐ Financial Statement/Billing

☐ 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. This request is valid for 30 days from date of signature.

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.

_____ _____**Subject to Fees

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

****PLEASE READ** Fee Information*: Klamath Orthopedic Clinic* contracts with ScanSTAT Technologies to copy and provide all medical records requested from our office. ScanSTAT 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 ScanSTAT Technologies with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay ScanSTAT Technologies for your records. In the case of continuity of care or personal copy to patient, ScanSTAT Technologies may transfer a minimal portion of your records as a courtesy.