**RELEASE OF INFORMATION (ROI) CONSENT FORM**

***Aspen Mountain Dermatology***

***2195 NW Shevlin Park Road | Bend, Or 97703***

***Phone: 541-706-3819 | Fax: 541-429-6659***

**AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

I, *[patient]*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_ authorize*[name of provider]*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to use and/or disclose my health information as identified below to: *[Name of recipient/Doctor]*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*[Address/Fax # of recipient/Doctor]*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following purpose(s): *[describe each purpose; if requested by patient and no purpose is identified, then may state “at the request of the individual”]*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

By ***INITIALING*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

\_\_\_\_**Send entire medical record** to the above named recipient

**OR**

\_\_\_\_**Send** **most recent history** to the above named recipient

*\*Includes up to 2 years chart notes, 2 years progress notes and last 3 labs as well as current medications list, allergy list, active problem list and immunization history.*

\_\_\_\_Clinician office chart notes \_\_\_\_Billing statements

\_\_\_\_Laboratory reports \_\_\_\_Pathology reports

\_\_\_\_Diagnostic imaging reports \_\_\_\_Emergency and urgent care records

\_\_\_\_Medical records needed for continuity of care \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*The following items must be ***INITIALED*** to be included in the use or disclosure of other health information:

\_\_\_\_**\***HIV / AIDS related health information and/or records

\_\_\_\_**\***Mental health information and/or records

\_\_\_\_**\***Genetic testing information and/or records

\_\_\_\_**\***Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

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I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

This authorization will remain in effect for one year from the date of signature unless a stop date is identified. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required.  If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640.  [insert applicable date or event of expiration]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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Signature of Individual or Individual’s Legal Representative Date