Drs. Fine, Hoffman and Sims, LLC

MEDICAL RECORDS RELEASE FORM

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section, describing your rights under the law. Patients have the right to access, inspect, and copy protected healthcare information used to make decisions about them.

Drs. Fine, Hoffman and Sims will only include information used to make decisions about the patient. Drs. Fine, Hoffman and Sims, may limit access to information generated only by this practice. Under some circumstances, such as increased risk of harm or injury, the practice may withhold the requested information. The Privacy Officer of this practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request if denied. If the Request is approved, Drs. Fine, Hoffman and Sims will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. Drs. Fine, Hoffman and Sims, may provide a summary of the requested information if the patient agrees.

Drs. Fine, Hoffman and Sims, provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name:____ D.O.B:___________________

Reason for releasing medical information: ____
Photo ID verified: ____________

I specifically authorize the release of the following information:
- □Treatment for the following diagnosis ____
- □Chart Notes – Specific Dates: From _______________ To ________________
- □Special testing and photographs
- □Correspondence
- □Operative reports

Is the summary of the information acceptable? □Yes □No
To **include** the following three categories from the requested records, initial below:

HIV/AIDS records _________ (Initial here for inclusion) Alcohol or drug treatment records __________ (Initial here for inclusion) Mental Health records ________ (Initial here for inclusion)

Please release my records **TO**: (please check one)
- □ Patient: I will pick up copies: ______________
- □ Patient: please **secure email** the copies to me at: ____
- □ Patient: please mail the copies to me at: ____
- □ Doctor: Doctor's name ____
  Address: ____

OR:

Please request my records be released **FROM**:
Doctor's name ____
Address: ____
- □ faxed to: Drs. Fine, Hoffman and Sims, 541-484-3883
- □ mailed to: Drs. Fine, Hoffman and Sims, 1550 Oak Street, Suite 5 Eugene, OR 97401
- □ electronically sent through secure portal at www.finemd.com

__________________________________ ________________________ _____________
(Signature of patient) (PRINTED NAME) (Date)

____ _____________
(Signature of Parent or Person Authorized by Law (if other than patient)

Relationship to patient: _________________________________