Ko-Kwel Wellness Center

630 Miluk Drive, PO Box 3190
Coos Bay, OR 97420
Phone (541) 888-9494 or (800) 344-8583
Fax (541) 888-5556

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
KO-KWEL WELLNESS CENTER - DIRECT CARE

Patients' Name: _____
First Middle Last

Date of Birth: _____ SS#: _____ - _____ - _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

From: **NAME:** KO-KWEL WELLNESS CENTER
ADDRESS: PO BOX 3190
CITY, STATE & ZIPCODE: COOS BAY, OR 97420

To: **NAME:** _____
ADDRESS: _____
CITY, STATE & ZIPCODE: _____

The purpose of this release is:
☐ Diagnostic Evaluation ☐ Follow-up Care
☐ Medical Treatment ☐ Other
☐ Continuity of Care

The information to be disclosed from my health record: (*Check* AND *Initial* appropriate boxes)
☐ Entire Record ☐ Other (specify): _____
☐ Only information related to (specify) _____
☐ Only the period of events from: _____ to: _____
☐ ***Psychotherapy Notes ONLY:*** By checking this box, I am waving any psychotherapist-patient privilege

By initialing the spaces below, I authorize
Release of the following information:
☐ HIV/AIDS related information
☐ Mental Health Information
☐ Genetic testing Information
☐ Drug/alcohol diagnosis, treatment, Or referral information

Release of the specific information is limited to the following:
Time Period of: _____
Treatment dates: _____

I understand that I may revoke this authorization in writing submitting at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, or if this authorization was obtained as a condition of providing insurance coverage, other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date here.
EXPIRATION DATE: _____

I understand that KWC will not condition treatment or eligibility for care on my providing this authorization except if such care is:1) research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) [45 CFR Part 164]. And the Privacy Act of 1974 [5 USC 552a]

Signature of Patient: _____ Date: _____
_____ Date: _____ Signature of Authorized Representative (state relationship to patient or Witness if signature is by thumb print or mark)

SUBMIT

Please download to computer to fill out, sign and submit this form.