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 Newberg, OR 97132
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Tualatin Office
 19250 SW 65th Ave
 Suite 300
 Tualatin, OR 97062
503.692.1242 Tel
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Medical Record # _____ **Authorization to Release Medical Information**

Patient Name _____ Other Name _____
 Birthdate _____
 Current Address _____
 Daytime Phone # _____ Social Security # _____

- REASON FOR RECORD**
- Personal
 - Medical Care
 - Benefits
 - Litigation
 - Workman's Comp
 - Other

I AUTHORIZE INFORMATION RELEASE FROM: _____
PLEASE SEND MY RECORDS TO: _____

Name of Facility _____ Facility to Receive Information _____
 Name of Physician _____ Title (Physician, Healthcare Facility, etc.) _____
 Address _____ Address _____
 City, State, Zip _____ City, State, Zip _____

Type of Information to be Released

Specific Information Only Please

PAP Results Genetics / Amniocentesis Operative Report Dates _____
 Mammogram Reports Immunizations Pathology Report Dates _____
 Medications / Therapy OB / GYN Records Ultrasound Report Dates _____
 Lab Other _____
 Radiology Reports
 History and Physical

General Medical Records (from the past two years only)

Notes:

Protected or Sensitive Information

Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

_____ I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.
Initials

_____ I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.
Initials

_____ I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.
Initials

_____ I recognize that the information disclosed may contain data regarding GENETIC TESTING. I specifically consent to disclosure of such information.
Initials

Permission to Fax Information: Yes No

_____ I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed.
Initials

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, *except*: to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) _____

THERE MAY BE FEES FOR PROVIDING COPIES.

Signature of Patient or Patient's Legal Representative _____ Date _____

Print Patient's Name or Name of Patient's Legal Representative (if applicable) _____ Relationship to Patient _____

Patient's or Legal Representative's Personal Identification Verified