



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

REASON FOR REQUEST
<input type="checkbox"/> Personal
<input type="checkbox"/> Medical Care
<input type="checkbox"/> Benefits
<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Permanent Transfer to a New Provider
<input type="checkbox"/> Other

Patient Name _____

Birth Date _____ Social Security # (Last 4 Digits) _____

Current Address _____

Daytime Phone # _____ Cell # _____

I AUTHORIZE INFORMATION RELEASE **FROM:**

INFORMATION TO BE RELEASED **TO:**

Note: If addresses are not provided, it may cause a delay in your request.

Name of Facility/Provider Sending Information

Name of Facility/Provider Receiving Information

Address of Facility/Provider

Address of Facility/Provider

City, State, and Zip Code

City, State, and Zip Code

Phone #

Fax #

Type of Information to be Released

- Chart Notes
- Immunization Records
- Other: _____
- Laboratory Results
- Medication Records
- X-Ray Reports only**
- Physical Therapy

** For film requests, call 503-399-2484, option 3.

Most Recent Visit Medical Records from _____ to _____ Last 2 years

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

Initials HIV / AIDS information

Initials Mental health information

Initials Drug / Alcohol diagnosis, treatment or referral information

Initials Genetic testing information

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your healthcare or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research. You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Privacy Officer at 2020 Capitol Street NE, Salem Oregon 97301, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization and state that you are revoking the Authorization. This Authorization will expire on the earlier of _____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose.

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

DATE

PRINT PATIENT'S NAME or NAME OF PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP to PATIENT