

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____

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

Current Address _____

Phone _____ Email _____

REASON FOR REQUEST	
<i>Please select one</i>	
<input type="checkbox"/>	Personal
<input type="checkbox"/>	Medical Care
<input type="checkbox"/>	Form(s)
<input type="checkbox"/>	Workers' Compensation
<input type="checkbox"/>	Permanent Transfer to a New Provider
<input type="checkbox"/>	Other _____

 I AUTHORIZE INFORMATION TO BE RELEASED **FROM:** _____

 INFORMATION TO BE RELEASED **TO:** _____

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 **Note: If addresses are not provided, it may cause a delay in your request.** _____ City, State, and Zip Code _____

Phone Number _____ Fax Number _____

Phone Number _____ Fax Number _____

Type of Information to be released:	
<input type="checkbox"/>	Visit Notes
<input type="checkbox"/>	Laboratory Results
<input type="checkbox"/>	Immunization Records
<input type="checkbox"/>	Medication Records
<input type="checkbox"/>	Form(s) - Type: _____
<input type="checkbox"/>	Imaging Reports - Type: _____
<input type="checkbox"/>	Imaging Pictures - Type: _____ <i>CT, MRI, X-Ray, etc.</i>
<input type="checkbox"/>	Other _____

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Select format & delivery method: (check one)	
Digital	Paper
<input type="checkbox"/>	DVD by mail
<input type="checkbox"/>	DVD pick-up
<input type="checkbox"/>	USB Device by mail
<input type="checkbox"/>	USB Device pick-up
<input type="checkbox"/>	Fax
<input type="checkbox"/>	Portal - MyChart, PowerShare, Requester (<i>Circle one</i>)
<input type="checkbox"/>	Mail - <i>Default if not selected</i>
<input type="checkbox"/>	Pick-up
<input type="checkbox"/>	Other _____

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Timeframe of Information to be released:	
<input type="checkbox"/>	Most Recent Visit
<input type="checkbox"/>	Specific Timeframe - from _____ to _____
<input type="checkbox"/>	Last 6 months
<input type="checkbox"/>	Last 2 years

Note: If no timeframe is selected, the last 6 months will be copied/printed. There may be fees for providing copies.

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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 _____ Mental health information _____ Genetic Testing information _____ Drug/Alcohol diagnosis, treatment or referral information	<i>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 records.</i>

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Incomplete and/or contradictory forms can cause delay in the release of records. Please make sure that you have addressed all fields, selected only one reason for release and only one delivery method. Thank you.

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 _____