Phone (541) 423-8151 Fax (541) 423-8508

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or person authorized by law to give authorization.

I hereby consent and authorize the release of medical information for:

Patient Name: ____ **Date of Birth:** ___________________________________

FROM:

____

(Name of Clinic/Hospital, Address, Phone number and Fax number)

TO:

____

(Name of Clinic/Hospital, Address, Phone number and Fax number)

By **INITIALING** the spaces below, I specifically authorize the release of the following medical records, if such exist.

______ All hospital records (including nursing records and progress notes)

______ Pathology reports

______ Medical records needed for continuity of care

______ Billing statements

______ Emergency and urgency care records

______ Other ______

______ Diagnostic imaging reports (current films only; please do not send films over two years old)

REASON FOR REQUESTED RECORDS: ____

If the information to be disclosed contains any types of records or information listed below, additional laws relation 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:

______ HIV/AIDS information ______ Genetic testing ______ Mental Health information

______ Drug/ Alcohol diagnosis, treatment, or referral information.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____________________________________ ____

Signature Date Signature of Person Authorized by Law Date

547 E Pine St, Suite 201
Central Point, OR 97502