orchid health
wade creek clinic

535 NE 6th Ave., Estacada, OR 97023
Office: (503) 630-8550
Fax: (503) 862-5060

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B. _____
Street, City, State, Zip

Home Phone _____ Work Phone _____ S.S.# _____

I Authorize Information Released FROM: (please print)
Name: _____
Address: _____
City, State, Zip:_____

Please Send My Records TO: (fax preferred)
Name: **Orchid Health Wade Creek Clinic**
535 NE 6th Ave. Estacada, OR 97023
Fax #: **(503) 862-5060**

Purpose of Release

❒ Transfer of care ❒ Insurance change ❒ Personal use
❒ Moving ❒ Referral/Consultation ❒ Legal

Type of Information To Be Released

❒ Complete Medical Records
❒ Psychiatric/Mental Health Records
❒ Records relating to Drug or Alcohol Treatment (must specify the extent of the records to be released):
_____
❒Other (specify): _____

This authorization will expire one year from the date of the signature below.
I understand that I can revoke this authorization at any time by writing to the health care provider or to Orchid Health Wade Creek Clinic, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information.
- I am entitled to receive a copy of this Authorization.

Patient or Authorized Representative Name (Please print) _____
(*If authorized representative please state relationship to patient)*

Patient or Representative Signature _____ Date _____