MEDICAL RECORDS RELEASE

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B. _____

_____ S.S.# _____

City, State, Zip

Best Contact Phone _____

I Authorize Information Released FROM: (please print)

Clinic/Doctor's Name: _____
Address: _____
City, State, Zip:_____

Please Send My Records TO: (fax preferred)

Orchid Health Wade Creek
535 NE 6th Ave.
Estacada, OR 97023
Fax: (503) 630-8551
Phone: (503) 630-8550

Orchid Health Oakridge
47815 Highway 58
Oakridge, OR 97463
Fax: (541) 782-5823
Phone: (541) 782-8304

Purpose of Release

❒ Establishing New PCP ❒ Sharing Health Information (from Consultant/Specialist) ❒ Personal Use ❒ Legal

Type of Information To Be Released- Initial **ALL** that apply

____**Complete** Medical Records ____ Include Mental Health Records ____Include Confidential Records/HIV or other

____ Include Records relating to Drug or Alcohol Treatment:_____

____Other (specify): _____

This authorization will expire one year from the date of the signature below.
I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health, but that any information already transferred will remain in our Confidential Medical Record System.

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 if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to receive a copy of this Authorization.

Signature _____ Date _____

Relationship to Patient: _____