orchidhealth
Exceptional, local healthcare

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)

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

❒ **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.

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

Signature ____ Date _______________