



Medical Records Release

Patient Name _____ Former Name (if any) _____
 D.O.B.: _____ Phone: _____
 Address _____ City _____ State _____ Zip _____

<p>I authorize information to be released FROM:</p> <p>Name/Facility: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p>	<p>I authorize information to be released TO:</p> <p>Name/Facility: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p>
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The purpose of this request is:

Referred Medical Care
 Transferring Care
 Personal
 Legal
 Other _____

Type of information to be released:

Complete Medical Records *(Consists of the last 2 years of treatment unless otherwise specified)*
 Other (Please specify): _____

MUST be INITIALED to be included with records

_____ HIV/AIDs related records
 _____ Mental Health related records
 _____ Genetic testing information
 _____ Drug/Alcohol** * *PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

All records will be sent though fax unless otherwise indicated. I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed.
 YES
 NO

My signature indicates that I authorize the disclosure of the above information and understand the following:
 I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment.
 I understand I can cancel permission to use and disclose my information at any time in writing. 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.
 I understand this change will not affect information that has already been shared.
 I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/ AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.
 I understand that I am allowed to receive a copy of this Authorization.

 Signature of Patient/Legally Responsible Person Relationship to Patient Date

Wade Creek Clinic
 535 NE 6th Ave • Estacada, OR 97023
 F: (866) 669-3334 Ph: (503) 630-8550

Oakridge Clinic
 47815 Hwy 58 • Oakridge, OR 97463
 F: (855) 313-2095 Ph: (541) 782-8304

Fern Ridge Clinic
 24934 Fir Grove Ln • Elmira, OR 97437
 F: (833) 673-0252 Ph: (541) 234-3255

McKenzie River Clinic
 51730 Dexter Street • Blue River, OR 97413
 F: (833) 905-2303 Ph: (541) 822-3341

Sandy Clinic
 37400 Bell St • Sandy, OR 97055
 F: (833) 903-3607 Ph: (971)220-2701

Hoodland Clinic
 24461 E Welches Road • Welches, OR 97067
 F: (833) 973-4292 Ph: 971-333-0494