

### Medical Records Release

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

<p><b>I authorize information to be released FROM:</b></p> <p>Name/Facility: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p>	<p><b>I authorize information to be released TO:</b></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 6<sup>th</sup> 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