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Canby, OR. 97013  
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**Oregon City**  
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Oregon City, OR. 97045  
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**Tigard**  
13200 SW Pacific Hwy.  
Tigard, OR. 97223  
503.598.2000  
503.639.0920 fax

## Authorization to Release Medical Information

Patient Name \_\_\_\_\_ Other Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Current Address \_\_\_\_\_

Daytime Phone # \_\_\_\_\_

**REASON FOR RECORD**

- Personal
- Medical Care
- Benefits
- Litigation
- Workman's Comp
- Permanent Transfer
- Other: \_\_\_\_\_

**I AUTHORIZE INFORMATION RELEASE FROM:**

**INFORMATION TO BE RELEASED TO:**

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Facility to Receive Information

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Title (Provider, Healthcare Facility, etc.)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
City, State, Zip

### Type of Information to be Released

**Specific Information Only Please**

- Chart Notes
- Laboratory Results
- X-Ray Reports/Films

- Immunization Records
- Medications Records
- Physical Therapy

Other: \_\_\_\_\_

**Most Recent Visit\***

**Medical records from \_\_\_\_\_ to \_\_\_\_\_\***

**Last 2 years only\***

*Note: If checkbox is not selected, entire record will be copied/printed. THERE MAY BE FEES FOR PROVIDING COPIES. \*Records more than 25 pages must be mailed not faxed*

**Protected or Sensitive Information**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

\_\_\_\_\_  
HIV / AIDS information  
Initials

\_\_\_\_\_  
Mental health information  
Initials

\_\_\_\_\_  
Genetic testing information  
Initials

\_\_\_\_\_  
Drug / Alcohol diagnosis, treatment, or referral information  
Initials

***I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.***

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this authorization in writing at any time, *except*: to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 24 months from the date of signing or on (insert applicable date or event) \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name or Name of Patient's Legal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

Patient's or Legal Representative's Personal Identification Verified