3818 SW 21st Street Suite 100 Redmond, Oregon 97756 (P) 541-548-2899 (F) 541-507-3781

Authorization for Release of Health Information

Name of Patient _____ Date of Birth _____

Street Address _____ Social Security Number _____

City, State, Zip _____ Phone Number _____

I do hereby authorize _____ to release the information checked below:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Office Visit Notes
- ☐ Billing Records
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Cardiology Records
- ☐ Consultations
- ☐ EKG Reports
- ☐ Progress Notes
- ☐ Other: _____

I authorize the release of information related to:

	I do	I do not
• Aids/HIV	☐	☐
• Psychiatric Care/Assessment	☐	☐
• Treatment for Alcohol/drug abuse	☐	☐

Information Released to: _____
Name of Company/Facility/Person

_____
Mailing Address or Fax Number

_____
City, State, Zip

Purpose of Disclosure:
Insurance ☐ Disability ☐ Personal ☐
Workers Comp ☐ Continuation of Care ☐ Legal Investigation ☐
Other _____

Unless revoked earlier this consent will expire 180 days from date of signing, to revoke this request please contact the Medical Records Department.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 30 days from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclose by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me on whether or not I sign the authorization. I understand and accept the statements contained in the authorization.

_____ _____
Signature of Individual (guardian or personal representative) Date