Authorization to Release Medical Information

Patient Name _____ D.O.B. _____

Current Address _____ Phone _____

I Authorize Information Released FROM: (Please Print)	Please Send My Records TO: (Please Print)
Name _____	Name _____
Address _____	Address _____
Phone/Fax Phone: _____ Fax: _____	Phone/Fax Phone: _____ Fax: _____

Purpose of Release

☐ Transfer of care ☐ Personal use ☐ Referral/Consultation

☐ Communication Only ☐ Legal ☐ Other: _____

Permission to Fax Information: 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

I would like records sent via: ☐ CD (Adobe 8 or higher) ☐ Paper (***If not checked, CD is the default method.)***

Type of Information To Be Released

☐ Entire Medical Record

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

Initial _____ Drug/Alcohol Diagnosis/Treatment/Referral Information

Initial _____ Genetic Testing Information

Initial _____ Mental Health/Treatment

Initial _____ HIV/AIDS Information

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment. You have the right to revoke this authorization at any time, provided that you do so in writing to Sellwood Medical Clinic. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

I understand that:

1. I am under no obligation to sign this form and completing this form is completely voluntary;
2. Unless otherwise revoked, this authorization will expire on the event that occurs first: one year from the date signed, the patient's 15th birthday, or specific date of my choice;
3. The person authorizing this release must sign, date, print his or her name, and indicate his or her relationship to the patient. No medical records of any type of a minor who is 15 years old or older, may be released without the minor's written authorization if the minor is self-consented to the treatment associated with the records. Sellwood Medical Clinic reserves the right to reject this authorization form if the legal authority of the representative cannot be validated.
4. Records sent to outside physicians/clinics/facilities are provided free of charge. All other requests are subject to fee provisions outlined within ORS 192.563.

BY: _____ DATE: _____

Patient or Patient Representative

Description of Representative's Authority: _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Sellwood Medical Clinic - Health Information Services
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