CORVALLIS
PAIN MANAGEMENT

# MEDICAL RECORDS REQUEST FORM

## PATIENT INFORMATION:

| | | |
|---|---|---|
| Patient Name: | | DOB: |
| Address: | | |
| City: | State: | Zip: |

## WHO DO YOU WANT TO RECEIVE YOUR INFORMATION:

| | | |
|---|---|---|
| Please share my records with: ☐ Myself at the contact information above ☐ The person or entity listed below: | | |
| Recipient name: | | FAX#: |
| Address: | | |
| City: | State: | Zip: |

## METHOD OF TRANSMISSION:

____Patient Pick-up ____Mail ____FAX

## PURPOSE OF DISCLOSURE:

____Continuing Care ____Personal Records ____Legal ____Insurance ____Other:_____

## INFORMATION TO BE RELEASED:

| | |
|---|---|
| ☐ Chart Notes<br>☐ Procedure Notes<br>☐ Imaging Reports | ☐ Billing Records<br>☐ Lab Reports |

Date range of Information: From: To:

I understand that this health information may include HIV/AIDS information and/or information relating to diagnoses or treatment of psychiatric disorders or substance abuse and/or genetic testing. By initialing below, I am specifically authorizing the release of information relating to: **PLEASE INITIAL BELOW**

| | |
|---|---|
| ____ Drug/alcohol diagnosis, treatment, or referral | ____ Mental Health |
| ____ HIV/AIDS | ____ Genetic Testing |

1. I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.
2. I understand that I may revoke this authorization at any time by notifying Corvallis Pain Management. This authorization will cease to be effective on the date notified.
3. This authorization will expire 1 year from the date signed or on this date: _____
4. A copy of this signed form will be provided to the patient or authorized representative as requested.

## SIGNATURE:

*The patient's signature is required. If the patient is a minor or is incapable of signing the authorization, a personal representative may be able to sign on the patient's behalf. Legal documentation showing the authority of the personal representative may be required.*

| | |
|---|---|
| Patient's signature: | Date: |
| Personal Representative Signature: | Date: |
| Representative Name: | Relation to Patient: |

RETURN COMPLETED FORM TO: Corvallis Pain Management 800 NE Circle Blvd, Corvallis, OR 97330
Fax: (541)201-8366 • Phone: (541)286-4742 • email: medical.records@corvallismed.com