Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

11900 SW Greenburg Rd
Tigard, OR 97223

Phone: (503) 620-5556
Fax: (503) 624-0118

Release of Records - Authorization to Disclose Protected Information

I do hereby consent and authorize Southwest Family Physicians to release or request copies of my medical records.

Patient name: _____ Date of birth: _____

Patient phone number: _____

REQUEST RECORDS FROM	RELEASE RECORDS TO
Facility name: _____	Facility name: _____
Address: _____	Address: _____
_____	_____
Phone number: _____	Phone number: _____
Fax number: _____	Fax number: _____

Please select the purpose for your request:

☐ Continuity ☐ Transfer of care ☐ Disability ☐ Insurance ☐ Legal ☐ Other: _____

This authorization shall begin immediately and remain in effect for not more than 180 days from today's date unless another date is specified.

Please select the specific information that applies to your request.

☐ Most recent 5 year history
☐ Clinical chart notes
☐ Prenatal/OB notes
☐ Other: _____
☐ Records related to (specific dates, conditions, etc.) _____
☐ Laboratory/Pathology
☐ Diagnostic Imaging Reports
☐ Immunizations

If the information to be disclosed or requested 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 or requested if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS _____Genetic testing _____ Mental health _____ Drug/alcohol information

Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such 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 service or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Patient signature (or authorized individual): _____ Date: _____

If signed by another person, indicate relationship: _____

PLEASE DO NOT SEND MEDICAL RECORDS BY CD - WE DO NOT ACCEPT THIS FORM OF RECORDS.