AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Oregon City Family Practice Clinic, P.C. 1420 John Adams St. Oregon City, OR 97045 PH: (503) 656-1484 FAX: (503) 650-1976

This Authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize: _____

_____

_____

To Release To: Oregon City Family Practice Clinic
1420 John Adams Street
Oregon City, OR 97045

Purpose of Release

☐ Dissatisfied with Practitioner ☐ Moved out of Service Area

☐ Dissatisfied with Staff Service ☐ Change of Insurance

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

___ All hospital records (including nursing records and progress notes)
___ Transcribed hospital reports
___ Medical records needed for continuity of care
___ Most recent five-year history
___ Laboratory reports
___ Pathology reports
___ Diagnostic imaging reports
___ Clinician office chart notes
___ Dental records
___ Physical therapy records
___ Emergency and urgency care records
___ Billing statements
___ Other _____

___ Please send the entire medical record (all information listed) to the above named recipient.
The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

___ *HIV/AIDS-related records
___ *Mental health information
___ *Genetic testing information
** *Must be initialed to be included in other documents*
___ *Drug/alcohol diagnosis, treatment or referral information as follows:
_____

** Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

___ This authorization is limited to the following treatment: _____
___ This authorization is limited to the following time period: _____
___ This authorization is limited to workers' compensation claim for injuries of _____ (date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 120 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Print patient name) **(Date of birth)**

_____ _____
(Signature of patient or person authorized by law) **(Date)**