



**Main Office:** 800 SW 13<sup>th</sup> Ave., Portland, OR 97205 (503) 221-0161  
**Beaverton Office:** 15950 SW Millikan Way, Beaverton, OR 97006 (503) 646-0161  
**South Office:** 6640 SW Redwood Lane, Portland, OR 97224 (503) 620-7358  
**Tigard Medical Campus:** 9250 SW Hall Blvd., Tigard, OR 97223 (503) 293-0161  
**Eye Services –Downtown:** 1115 SW Taylor, Portland, OR 97205 (503) 227-0354  
**Eye Services – Beaverton:** 15950 SW Millikan Way, Beaverton, OR 97006 (503) 643-1166  
**Ambulatory Surgical Center:** 800 SW 13<sup>th</sup> Ave, Portland, OR 97205 (503) 221-0161  
**Appointments:** Vancouver Direct Dial: (360) 693-3532 (503) 223-3113

**Authorization to Release Medical Information to The Portland Clinic**

USE THIS FORM TO HAVE RECORDS SENT TO YOUR PROVIDER AT THE PORTLAND CLINIC

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Former Name \_\_\_\_\_  
 Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_ SS# \_\_\_\_\_

I authorize information released from:

Please send my records/films to (check one):

\_\_\_\_\_  
 Physician/or other third party named  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City, State, Zip

- Main Office: 800 SW 13<sup>th</sup> Ave., Portland, OR 97205
- Beaverton Office: 15950 SW Millikan Way, Beaverton, OR 97006
- South Office: 6640 SW Redwood Lane, Portland, OR 97224
- Tigard Medical Campus: 9250 SW Hall Blvd., Tigard, OR 97223
- Eye Services –Downtown: 1115 SW Taylor, Portland, OR 97205
- Eye Services – Beaverton: 15950 SW Millikan Way, Beaverton, OR 97006
- Ambulatory Surgical Center: 800 SW 13<sup>th</sup> Ave, Portland, OR 97205

**INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW**

**General Medical Records** –excluding protected records.

Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and immunizations.

**-OR-**

**Specific Information Only:**

- History and Physical specify date \_\_\_\_\_
- Medications/Therapy \_\_\_\_\_
- Lab, Pathology, EKG specify type or date \_\_\_\_\_
- X-ray reports specify type or date \_\_\_\_\_
- Operative report specify type or date \_\_\_\_\_
- Accident or injury dates from \_\_\_\_\_ to \_\_\_\_\_
- Immunizations only \_\_\_\_\_
- Other \_\_\_\_\_

**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.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT	_____ SEXUALLY TRANSMITTED DISEASES
INITIAL _____	INITIAL _____
_____ ALCOHOLISM DIAGNOSIS/TREATMENT	_____ AIDS/HIV TEST RESULTS INCLUDING
INITIAL _____	INITIAL _____ RELATED HIGH RISK BEHAVIOR
_____ MENTAL HEALTH/TREATMENT	_____ GENETIC TESTING
INITIAL _____	INITIAL _____

\_\_\_\_\_  
 Signature of patient or legally responsible person relationship to patient date

**RETURN THIS FORM TO THE FACILITY WHO WILL BE PROVIDING COPIES OF YOUR RECORDS**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis treatment or referral information. I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so. 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 services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a healthcare plan or eligibility to enroll in the health plan unless the authorized information is necessary to determine if I am eligible in the health plan. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my Authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 90 days from the date of signing or on (insert applicable date or event) \_\_\_\_\_.