THE Portland Clinic

RETURN THIS FORM TO RELEASE OF INFORMATION [ROI] AT
THE SOUTH OFFICE 6640 SW REDWOOD LANE, PORTLAND OR 97224
OR FAX TO 503-620-5348

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

Patient Name _____ DOB _____ Former Name _____

Current Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening phone _____ SS# _____

I authorize information to be sent to:

_____
Physician/or Other Third Party Named

_____
Address

_____
City, State, Zip

Purpose of Release: check one box

- ☐ Changing Primary Care Physician/Clinic *
- ☐ Referral/Consultation *
- ☐ Insurance **
- ☐ Legal **
- ☐ Personal Use/Other **

* Records sent to outside physicians/clinics are provided as a courtesy.
** Fees may apply: the rate is $25 for the first 10 pages and .25 cents each additional page plus postage.

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. Please contact the Release of Information office directly if additional information is needed.

-OR-

Specific Information Only:

- ☐ History and Physical — Specify Date _____
- ☐ Medications/Therapy
- ☐ Lab, Pathology, EKG — Specify Type or Date _____
- ☐ X-ray Reports
- ☐ Films — Type_____ Date Taken_____ Report _____
- ☐ 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.

_____ INITIAL DRUG ABUSE DIAGNOSIS/TREATMENT

_____ INITIAL ALCOHOLISM DIAGNOSIS/TREATMENT

_____ INITIAL MENTAL HEALTH/TREATMENT

_____ INITIAL SEXUALLY TRANSMITTED DISEASES

_____ INITIAL AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR

_____ INITIAL GENETIC TESTING

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

_____ Signature of Patient or Legally Responsible Person

_____ Relationship to Patient

_____ Date