



# Authorization to Release Medical Information

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

I Authorize the Release of Medical Information FROM The Portland Clinic

**←OR→**  
(select one)

I Authorize the Release of Medical Information TO The Portland Clinic

\_\_\_\_\_  
Physician/or other third party named

\_\_\_\_\_  
Address City, State, Zip

\_\_\_\_\_  
Physician/or other third party named

\_\_\_\_\_  
Address City, State, Zip

\_\_\_\_\_  
Phone # Fax #

**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.

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

- Main Office: 800 SW 13th 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
  - Columbia - 5847 NE 122<sup>nd</sup> Ave. Suite 201, Portland, OR 97230
  - East - 541 NE 20<sup>th</sup> St., Suite 210, Portland, OR 97232
- Provider Name \_\_\_\_\_ Fax# \_\_\_\_\_

**Purpose of Release: check one box**

- Changing Primary Care Physician/Clinic
- Referral/Consultation
- Other: \_\_\_\_\_

**Return to:** The Portland Clinic South-Release of Information Department  
 6640 SW Redwood Lane, Portland, Oregon 97224  
 Fax# 503-620-5348

**Return to:** Facility who will be providing copies of your records.

### 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 \_\_\_\_\_
- Images type \_\_\_\_\_ date taken \_\_\_\_\_ report \_\_\_\_\_
- Operative report specify type or date \_\_\_\_\_
- Accident or injury dates from \_\_\_\_\_ to \_\_\_\_\_
- Immunizations only \_\_\_\_\_
- Billing \_\_\_\_\_
- 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**  
9002 (8/17)

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**