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

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.

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

_____
Physician/or other third party named

_____
Address City, State, Zip

_____
Phone # Fax #

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 122nd Ave. Suite 201, Portland, OR 97230
- ☐ East – 541 NE 20th 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: 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**

_____ **Relationship to Patient**

_____ **Date**