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 ☐ *I Authorize the Release of Medical Information TO The Portland Clinic*

(select one)

_____
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
- ☐ Northeast – 5005 NE Sandy Blvd, Portland, OR 97213

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**

The Portland Clinic

Medical Records / Release of Information (ROI) Department Information Sheet

General information and instruction on how to complete your Medical Record Release of Information Request.

Return completed Release of Information forms by one of these methods:

Mail: The Portland Clinic, Attn: Release of Information Department
6440 S.W. Redwood Lane
Portland, OR 97724

Fax: 503-620-5348

Email: Scan and attach the original completed and signed of the Release of Information form and email tpcroi@tpcllp.com

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- The Medical Records / Release of Information Department is open and our staff is available to answer your questions between the hours of 7:30 a.m. to 4:00 p.m. Monday through Friday.

  Medical Records / Release of Information Department Direct: 503-620-7358 ext. 2900

- If your request is for **X-Ray films ONLY**, contact the **Film Library Department**.

  Phone: 503-221-0161 ext. 2197 or Fax: 503-790-1053

- **If your call is after business hours** you may leave a message for one of our staff to return your call the next business day.

- **You may arrange to pick up your medical records** in person. Call the Release of Information department prior to arriving to ensure that your request for medical records has been completed and is ready for pick up before coming to the office.

- **If someone other than yourself is picking up your records.** *We must have a signed written authorization from you on file prior to releasing your records to anyone other than yourself.* Your authorized representative will be required to present an official photo identification prior to the records release. (Driver's license, passport, military ID are the most common types of ID.) The medical records will be released in a sealed envelope for your privacy.

- For your convenience, please visit us online at: **https://www.theportlandclinic.com** to obtain Release Forms.

  1. ***Click on*** **"Resources"** at the top of the page
  2. ***Click on*** "**Find Patient Forms"**
  3. ***Scroll down the page*** to "**Release of Information"**
  4. **Download and print** the appropriate form

- You may also find the information you need located in your personal medical record online by using The Portland Clinic MyChart at: **https://mychart.tpcllp.com/MyChart**