

Authorization for Release of Information

Patient Information (please PRINT):

Last Name _____ First Name _____ M _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Information to be Released From: _____

Name of Provider or Facility

Address

City/State

Zip Code

(____) _____

Phone Number

(____) _____

Fax Number

Information to be Released To: _____

Name of Provider or Facility

Address

City/State

Zip Code

(____) _____

Phone Number

Fax Number

(____) _____

By **initialing** the space below, I specifically authorize the release of the following medical records, if such records exist:

- | | |
|--|---|
| <input type="checkbox"/> office chart notes | <input type="checkbox"/> all hospital records including outside facilities |
| <input type="checkbox"/> laboratory/pathology reports | <input type="checkbox"/> all diagnostic reports and actual films (No CD's) |
| <input type="checkbox"/> physical therapy reports/notes | <input type="checkbox"/> financial records/ledgers |
| <input type="checkbox"/> this release is restricted to _____ | <input type="checkbox"/> condition and/or treatment |

It is the policy of Multnomah Orthopedic Clinic not to release the records of another healthcare provider that may be in your chart. A note may be made and released as to the author and date of such records.

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization of these records to be released.

Exclude the following information from the records being released (please initial):

- | | |
|---|---|
| <input type="checkbox"/> drug/alcohol abuse/treatment & diagnosis | <input type="checkbox"/> sexually transmitted disease |
| <input type="checkbox"/> HIV/AIDS diagnosis/treatment/testing | <input type="checkbox"/> mental illness/psychiatric diagnosis/treatment |

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Privacy Notice to patients, posted at the facility where your information is being released). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-close it, at which time it may no longer be protected under privacy laws.

SIGNATURE: _____

DATE: _____

***This authorization expires 90 days after date signed.
Possible copying fee applicable***