

**1215 NE 7th ST Ste D Grants Pass, OR 97526**

**Phone (541) 244-2197 Fax (541) 244-2199**

**Authorization to Request -or- Release Medical Records  
*(if more than 30 pages, please send on a disc or USB)***

Patient Name Date of Birth

Address

Day Time Phone

**RELEASED FROM: RELEASE TO:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Name Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip City/State/Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Fax # Phone # Fax #

Purpose for release: ❒ Transfer of Care ❒ Referral/Consultation ❒ Other/Personal

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

Please initial for release of records. ***UNACCEPTABLE WITHOUT INITIALS (initials must be handwritten, not typed)***

All items below

Chart notes Surgery Reports Diagnostic imaging reports \_\_\_\_\_\_\_\_

Lab reports Pathology Reports Most recent 3 year history \_\_\_\_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

HIV/AIDS information Mental health information Genetic testing

Sexually transmitted disease information

Alcohol/chemical dependency diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

**If you would like a copy of your medical records, a processing fee may be charged. Expedited processing or sending records by first class mail will incur additional fees.**

**AUTHORIZATION TO RELEASE INFORMATION:**

**Patient Signature (cannot be typed) Date Patient Representative Signature Date**

*\*This authorization is valid for six months and may be revoked by the patient (orally or in writing) at any time prior to six months\**