ROGUE MEDICINE

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