Providers of:
Oregon Psychiatric Partners, L.L.P. & Franc Strgar, MD, P.C
3203 Willamette St. ~ Eugene, OR 97405
1831 NW Kings Blvd, Corvallis OR 97330
Phone 541-726-9912 ~ Fax 541-744-4443

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

Other Names Used: _____

For the purpose(s) of continuity of care, diagnosis, evaluation and treatment planning, I authorize my provider(s) at **OREGON PSYCHIATRIC PARTNERS, LLP, & FRANC STRGAR MD, PC** to release the following confidential information about me to the physician or organization listed below.

_____
(Name of Physician or Organization)

_____
(Address) (Telephone) (Fax)

By placing my initials here _____ I authorize the physician or organization listed above to release my medical record and information to my provider(s) at OREGON PSYCHIATRIC PARTNERS, LLP & FRANC STRGAR MD, PC.

I understand my record may include medical, mental health, and drug/alcohol diagnostic evaluations, treatment history, progress notes, summaries, medication history, laboratory test and reports, and hospital and immunization records.

I understand the following information can only be disclosed if I initial below. I further understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, and HIV/AIDS diagnoses and treatment information, and specific authorization is required for the release of such information.

_____ Mental Health records which may including drug/alcohol diagnoses and treatment or referral information
_____ HIV/AIDS related information and/or records
_____ Genetic Testing information and/or records

Please indicate purpose for this release:

☐ **Ongoing:** To Allow ongoing communication between my care providers.

☐ **Single Event**: This is a one-time request to transfer all my records from Oregon Psychiatric Partners to the entity listed above.

If you are requesting a specific record to be released, please specify the document below:

_____

By signing below:

I authorize the release of the medical records noted above and I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

I understand this release will remain in effect until:

☐ My care is terminated by my provider or myself.

☐ The designated time period of _____ days has lapsed.

☐ The single event has been fulfilled, which I understand may take 30 days from the date of the request.

I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a written request to cancel. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request.

I agree I have read the entire release and I understand this authorization is voluntary and I may refuse to sign the authorization. I understand if I do not sign this authorization it will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____ _____
Date Signature of Patient or Guardian Type of Guardianship