*Patient - Please **ONLY** sign and date at the bottom

Dr. Joseph J. Hamlin, D.C
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Authorization to Disclose Medical Records

Patient Name:_____ Patient DOB: _____

Information to be released from:
Name of facility and/or provider: _____ City: _____State: ____ Phone: _____ Fax: _____

Information to be sent to: **Oregon Spine and Disc**
5035 NE Elam Young Pkwy. Suite 300 Hillsboro, OR 97124
P.503-626-3700 F.503-643-6667

Purpose of disclosure:
The information will be used on my behalf for the following purpose:_____

Information to be released:
By initialing spaces below, I specifically authorize the release of the following medical records, if such records exist.

____Medical records needed for continuity of care
____Laboratory reports
____Pathology reports
____Diagnostic Imaging
____Other (please Specify)_____
____Most recent 5 year history
____Clinician office chart notes
____Physical therapy records
____Billing records and statements

___Please send the entire medical record (all information) to the above name recipient.
Recipient understands this record may be voluminous and agrees to pay reasonable charges associated with providing records.

____HIV / Aids related records.
____Mental health information.
____Genetic testing information.
____Drug/Alcohol diagnosis, treatment, referral.
***Must be initialed to be included in other documents.**

Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.
____This authorization is limited to the following treatment:_____
____This authorization is limited to the following time period_____
____This authorization is limited to a worker's compensation claim for injuries of_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____
Patient Signature
Date_____

_____
Person Authorized by Law Signature
Date_____