

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



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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.

- | | |
|--|---|
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Most recent 5 year history |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Physical therapy records |
| <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Billing records and statements |
| <input type="checkbox"/> Other (please Specify) _____ | |

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.

- | | |
|--|---|
| <input type="checkbox"/> HIV / Aids related records. | <input type="checkbox"/> Genetic testing information. |
| <input type="checkbox"/> Mental health information. | <input type="checkbox"/> 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 _____