Authorization for Release of Information

Patient Information (please PRINT):

Last Name___________________________ First Name_______________________ M________

Date of Birth________________ Social Security Number______-_______-_______

Information to be Released From:____

Name of Provider or Facility

____

Address City/State Zip Code

(____)_________________ (_____)__________________

Phone Number Fax Number

Information to be Released To:____

Name of Provider or Facility

____

Address City/State Zip Code

(____)_________________ (_____)__________________

Phone Number Fax Number

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

___office chart notes
___laboratory/pathology reports
___physical therapy reports/notes
___this release is restricted to ___________________condition and/or treatment
___all hospital records including outside facilities
___all diagnostic reports and ***actual films (No CD's)***
___financial records/ledgers

It is the policy of Multnomah Orthopedic Clinic not to release the records of another healthcare provider that may be in your chart. A note may be made and released as to the author and date of such records.

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization of these records to be released.

Exclude the following information from the records being released (please initial):

___drug/alcohol abuse/treatment & diagnosis
___HIV/AIDS diagnosis/treatment/testing
___sexually transmitted disease
___mental illness/psychiatric diagnosis/treatment

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Privacy Notice to patients, posted at the facility where your information is being released). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-close it, at which time it may no longer be protected under privacy laws.

SIGNATURE:____ **DATE:**______________

This authorization expires 90 days after date signed.
Possible copying fee applicable