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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: ______________________________

Date of Birth: ________________ Social Security Number: ______________________

I hereby authorize:

Oregon Orthopedic & Sports Medicine Clinic, LLP
1508 Division Street, Suite 105
Oregon City, OR 97045

To provide medical information to:

____
(Name of Individual/Facility/Agency)

____
(Address)

____
(City, State, Zip Code)

I authorize ______________________________ to pick up my records.
(Name of Individual)

Data Requested:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Laboratory Reports
- ☐ Operative/Pathology Reports
- ☐ Emergency Dept./Hospital Records
- ☐ X-Rays ☐ MRI
- ☐ Reports ☐ Films
- ☐ Clinical Chart Notes
- ☐ Entire Record
- ☐ Other: ______________________

Permission to fax and/or send electronically ☐ YES ☐ NO
All faxed material will contain a confidentiality statement; however, I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

______________________________ ______________________________
Patient Signature Date Parent, Legal Guardian, Representative Date

This release is effective for six months from the date it is signed, or expires on: ______________________
Date

By **CHECKING and SIGNING**, I specifically authorize the release of the following confidential information:

- ☐ HIV test and test results and related information including high risk behavior documentation
- ☐ Drug/Alcohol diagnosis, treatment or referral information
- ☐ Mental Health treatment information
- ☐ General information

______________________________ ______________________________
Patient Signature Date Parent, Legal Guardian, Representative Date