



Thomas P. McWeeney, MD, PC
 Terrence A. Sedgewick, MD, PC
 Bradford T. Black, MD, PC
 James C. Ballard, MD, PC
 David P. Huberty, MD, PC
 Jeffrey S. Feinblatt, MD
 John D. Boyle, PA-C
 Tessa J. Molter, PA-C
 David C. Emch, PA-C

Oregon City Office: 1508 Division Street, Suite 105, Oregon City, OR 97045 Tel: (503) 656-0836 Fax: (503) 656-9464
Tualatin Office: 19250 SW 65th Ave, Suite 100, Tualatin, OR 97062 Tel: (503) 692-0366 Fax: (503) 691-6167
 Visit our website: www.pdxortho.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize:

 (Name of Individual/Facility/Agency)

 (Address)

 (City, State, Zip Code)

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:

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-Rays | <input type="checkbox"/> MRI |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Reports | <input type="checkbox"/> Films |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Clinical Chart Notes | |
| <input type="checkbox"/> Operative/Pathology Reports | <input type="checkbox"/> Entire Record | |
| <input type="checkbox"/> Emergency Dept./Hospital Records | <input type="checkbox"/> 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