Patient Name: ____________________________________ **Medical Record #:**______________________

Address: ____ **Date of Birth**___________________

City/State/Zip____ **Phone:**________________________

Please RELEASE Information FROM:	**Please RELEASE information TO:**
_____________________________________	_____________________________________
Name	Name
_____________________________________	_____________________________________
Street Address	Street Address (or specified fax number)
_____________________________________	_____________________________________
City/State/Zip	City/State/Zip
_____________________________________	_____________________________________
Telephone Number	Telephone Number
_____________________________________	_____________________________________
Fax Number	Fax Number

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

____

____

For the Purpose of: ❑ Patient Care ❑ Insurance Claim ❑ Self ❑ Other _________________________

List specific dates of records to be released: ____

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows: __________________ (date or event.)

The following must be INITIALED by the requestor to be included in the use and/or disclosure:
_____*HIV/AIDS related information and/or records _____Mental Health Information
_____Genetic Testing information _____**Drug/alcohol diagnostics, treatment, or referral information

***This information may not be re-disclosed without the specific written authorization of the individual, except where authorized by law.**
****Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.**

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

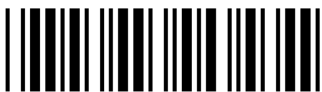
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see back of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see back of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature:____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship:____

Adventist Medical Center, Portland, Oregon

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: OREGON



Authorization to Release Medical Info

46096 Rev. 2/08

Legal Docs

Retain in Patient Record

For Office Use Only

Date Received: ___________________________ **Date Information Released:** _____________________________

☐ **Copy of verification of identity of individual and/or legal representative obtained/filed.**

Notes:____

____

____________________________ _____________
Medical Record Number **Clerk Initials**

Revocation of Authorization

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

☐ **Above Authorization**
☐ **Authorization releasing information to** ____
☐ **Authorization dated** _________________________

Signature:____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: ____

For Office Use Only

Date Revocation Received:____

_______________________________ ___________
Medical Record Number **Clerk Initials**

Exceptions:

The exceptions noted in the Rights section on front of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.