[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwjNueqt0s7YAhVM_mMKHXDwC40QjRwIBw&url=http://www.hudsonmedicalservices.com/index.php/who-we-assist/&psig=AOvVaw0cXfccWXvFEr6i9lXPqnb5&ust=1515716564219768)



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization

**Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize the release of medical information regarding the patient named above by copy of medical records and/or by discussing the information in person or by phone.

**From** (Facility/Physician/Individual) **PENDLETON FAMILY MEDICINE**

2450 SW Perkins Ave Pendleton, OR 97801

Phone: 541-276-1700 Fax: 541-276-6327

**To** (Facility/Physician/Individual) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Fax**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Purpose of Disclosure:**

\_\_\_\_Changing Primary Care \_\_\_\_Referral \_\_\_\_Personal Use \_\_\_\_Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Specify Reason

**Date Range:** \_\_\_\_Most Recent 2 Year History

\_\_\_\_Dates of Service From \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to fax information:** \_\_\_\_\_No \_\_\_\_ Yes: I specifically consent to the faxing of my protected health information. All faxed material will contain a confidentiality statement. However; I understand confidentiality at the receiving end cannot always be guaranteed.

**Type of Information to be released:**

**\_\_\_\_\_\_**Any and all medical records needed for continuity of care (chart notes, labs, x-rays, special tests, etc)

\_\_\_\_\_\_Chart Notes \_\_\_\_\_ Labs/Pathology Reports \_\_\_\_\_ X-ray Reports \_\_\_\_\_Special Tests

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by Federal State Law. By **initialing**, I authorize the release of the following protected or sensitive information:

\_\_\_\_\_Drug Abuse Diagnosis/Treatment \_\_\_\_\_\_Mental Health Treatment

\_\_\_\_\_Alcoholism Diagnosis Treatment \_\_\_\_\_\_AIDS/STD Test Results & Related Information

This authorization may be revoked at any time. The only exception is when action had been taken in reliance on the authorization.

Unless revoked earlier, this consent will expire in one (1) year from the date of signing and shall remain in effect for the period reasonably needed to complete the requirement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient OR Signature of Authorized Person Date