|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name** |       |  | **Date of Birth** |       |
| **ID# (if known)** |       |  |

**▶ Instructions: Complete each section of the form in its entirety.**

|  |  |  |
| --- | --- | --- |
| **Release Information From** |  | **Release Information To** |
|  |       |  |  |  |       |  |
| Name/Facility |  | Name/Facility |
|  |       |  |  |  |       |  |
| Address |  | Address |
|  |       |  |  |  |       |  |
| City/State/ZIP |  | City/State/ZIP |
|  |       |  |  |  |       |  |
| Phone |  | Phone |

**▶ Purpose of Release**

|  |
| --- |
|  |

**▶ Delivery Method** *(check ONLY 1)*

|  |  |  |
| --- | --- | --- |
| **[ ]  Release by Email to:** |       |  |
| **[ ]  Release by Fax to:** |       |  |
| **[ ]  Release by Other method to** (e.g., phone)**:** |       |  |
| **[ ]  Release by Mail to Name/Facility indicated above** |

**▶ Information to be Released**

|  |
| --- |
| By placing my INITIALS next to the information below, I specifically authorize the release of the following medical records, if such records exist: |
| **[ ]  Record Dates from** |       | **to** |       | **— OR [ ]  All Available Service Dates** |
|  |
|  | **INITIALS** |  | **INITIALS** |  |
|  |       | All medical records |       | Immunization History |  |
|  |       | Behavioral Health/Mental Health records |       | Laboratory Reports |  |
|  |       | Dental Records |       | Radiology Reports |  |
|  |       | Other (explain) |       |  |
|  |

**▶ Information to be Released**

|  |
| --- |
| By placing my INITIALS\* next to the information below, I specifically authorize the following information to be used, disclosed, or received, if such records exist: |
|  | **INITIALS\*** |  | **INITIALS\*** |  |
|  |       | \*\*HIV/AIDS-related records |       | \*\*Alcohol and Drug information |
| *\* Must be initialed to be included with other records. Records will not be released without your initials specifying that you have granted this specific release authority.* |

**▶ Authorization**

My signature below indicates that I authorize the disclosure of the above information and understand the following:

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice and that this authorization automatically expires after one (1) year from the date signed. I understand the cancellation will not affect any information that was released before the cancellation. I approve the release of this information. I understand that information about my case is confidential and protected by state and federal law. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Patient |  | Date |
|  |  |  |
| Signature of legal/personal representative authorized by law, if applicable |  | Date |

*\*\* Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit information recipients from making any further disclosures of Alcohol and Drug information and state statute ORS 433.045 and administrative rule OAR 333-12-270 prohibit further disclosure of HIV/AIDS information, and statutes ORS 659.700-659.720 prohibit further disclosure of genetics information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*