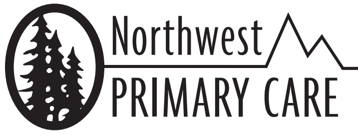

Authorization to Release Medical Information

Patient Name ______________________ (PLEASE PRINT) Former Name (if any) ______________________

Current Address ______________________ (P.O. BOX OR STREET, CITY, STATE, ZIP) D.O.B. __________

Home Phone ______________ Work Phone ______________ S.S.# ______________

I AUTHORIZE INFORMATION RELEASED FROM:	**PLEASE SEND MY RECORDS TO:**
Name of Facility or Practitioner	Facility or Practitioner to Receive Information
Address	Address
City, State, Zip	City, State, Zip

Purpose of Release: ✓ (Please check one)

TRANSFER OF CARE

- ❑ DISSATISFIED WITH PRACTITIONER
- ❑ MOVED OUT OF SERVICE AREA
- ❑ DISSATISFIED WITH STAFF SERVICE
- ❑ CHANGE OF INSURANCE

COORDINATION OF CARE

- ❑ REFERRAL/CONSULTATION
- ❑ PERSONAL USE
- ❑ LEGAL
- ❑ OTHER: ______________

Permission to Fax Information: ❑ Yes ❑ No

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be guaranteed.

I would like my records sent to me: ❑ CD (Adobe 8 or higher) ❑ Paper (Default is CD)

Type of Information To Be Released

- ❑ GENERAL MEDICAL RECORDS (CONSISTS OF LAST TWO YEARS ONLY)
- ❑ **SPECIFIC INFORMATION ONLY**: please specify ______________________

✍ **PROTECTED OR SENSITIVE INFORMATION:** I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

Initial		Initial	
________	DRUG ABUSE DIAGNOSIS/TREATMENT	________	MENTAL HEALTH/TREATMENT
________	ALCOHOLISM DIAGNOSIS/TREATMENT	________	SEXUALLY TRANSMITTED DISEASES
________	AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIORS		

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this Authorization at any time, provided that you do so in writing to Northwest Primary Care Group. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

This Authorization will expire in 180 days from the date of signing, or unless otherwise specified ______________________.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: ______________________ (Patient or Patient Representative) Date: ______________

Description of Representative's Authority: ______________________

❑ *Dwyer Clinic*
Internal Medicine
10024 SE 32nd Ave. • Milwaukie, OR 97222
(503) 659-4988 phone • (503) 654-5666 fax

❑ *Milwaukie Family Practice*
Total Family Care
3033 SE Monroe St. • Milwaukie, OR 97222
(503) 659-4988 phone • (503) 659-4730 fax

❑ *Talbert Center*
Total Family Care
12360 SE Sunnyside Rd. • Clackamas, OR 97015
(503) 659-4988 phone • (503) 698-4018 fax

❑ *Sellwood / Moreland*
Total Family Care
6327 SE Milwaukie Ave. • Portland, OR 97202
(503) 659-4988 phone • (503) 353-1297 fax

❑ *Oregon City Clinic*
Total Family Care
1508 Division St. • Plaza 2, Suite 25
Oregon City • OR 97045
(503) 659-4988 phone • (503) 353-1234 fax

❑ *Medical Records*
12300 SE Mallard Way, Suite 160 • Milwaukie, OR 97222
(503) 659-4988 phone • (503) 353-1293 fax

1060 (11/12)

Instructions for completing NWPC Record Release Form:

(Important: any missing or inaccurate entries may delay or void your request)

- Photo ID may be required for patient/guardian verification
- Be sure to write legibly, to include:
    - Birth date
    - Previous name (if any)
    - Where you would like the records sent (include address or fax number)
    - Why the records are being sent (purpose of release)
    - Type of information to be released (standard for "all records" is last two years unless specifically requested otherwise).
    - Patient/guardian signature and date
- If you want the information to be faxed, please mark on the form, "Permission to Fax". Please note that we will not fax any records that are more than 50 pages.
- It is our policy to not include any records prior to being treated at NWPC.
- Please allow 30 days for records to be sent, per Oregon State Law.

Who can get copies of medical records:

- Adult patients may ask for copies of their own medical records.
- Parent or legal guardian may ask for copies of their minor child's medical records.
- A person with a legal power of attorney may ask for copies of the medical records of someone named in the power of attorney (for example, wife, husband or partner, or a disabled adult).
- The legal next of kin may ask for copies of a deceased patient's medical records.