OREGON FAMILY HEALTH, LLC
607 SE Jefferson Street Dallas, Oregon 97338
Phone (503) 623-1200 Fax (503) 623-1414

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I desire to release the medical information for the patient indicated below for the purposes of establishing and coordinating care and updating records maintained at Oregon Family Health. I understand that my establishing or receiving medical care is NOT contingent upon signing this form. I understand the release of this information is intended to assist the physicians at Oregon Family Health to care for the patient indicated below.

I understand this authorization may be revoked in writing at any time by providing a written statement to the address above. No revocation will be retroactive to pertain to records already released. This consent will expire one year from the date of signing unless otherwise indicated.

I understand the information used or disclosed may be subject to re-disclosure except for highly confidential information to include "Sensitive Information."

The undersigned hereby releases Oregon Family Health from any liability which may arise from the release and/or examination of the information indicated above. I have read this authorization, and I understand it.

I authorize _____ at _____ to release a copy of medical
Hospital/Health Care Provider Phone Number

information for _____ _____
Patient's Name Patient's Date of Birth

Patient's Address: _____ (____ __) _____
Patient's Phone Number

_____

to Oregon Family Health, 607 SE Jefferson Street, Dallas, Oregon 97338 ph (503) 623-1200, f (503) 623-1414.

I specifically authorize the release of the following records:

*****TO AVOID SPENDING UNNECESSARY TIME/RESOURCES, PLEASE LIMIT RECORDS TO PREVIOUS TWO YEARS UNLESS INFORMATION IS FUNDAMENTAL TO THE CARE OF THIS PATIENT. THANK YOU.*****

____ *Most recent* Chart Note(s) for each chronic condition ____ Diagnostic Reports (EKG, Radiology, EMG, etc)

____ Hospital Discharge Summary ____ Pathology Reports

____ Most Recent Laboratory Results ____ _____

____ Specialist Consultations including: _____

By initialing, I authorize the release of the following "Sensitive Information" information.

_____ HIV/AIDS records _____ Mental Health records _____ Drug/alcohol related records ____ Genetic Testing

_____ _____
Date Signature of patient or person authorized by law

ofh 12/2012