

Record Release Form
DOCTOR'S FAMILY CLINIC & IMMEDIATE CARE

9735 SW Shady Lane • STE 100 • Tigard, Oregon 97223 • (503) 639-2800 • FAX (503) 639-4044
2870 SW Cedar Hills Blvd. • Beaverton, Oregon 97005 • (503) 646-9222 • FAX (503) 350-1226

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Shady Lane	Cedar Hills
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Patient Name: _____ Date of Birth: (___/___/___)

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

1. I authorize _____ (name of provider) (address)		
_____	_____	_____
(city)	(state)	(phone)
to disclose my health information for the purpose of: _____		
2. To: _____ (name of provider/individual) (address)		
_____	_____	_____
(city)	(state)	(phone)
3. For the date range: From: (___/___/___) To: (___/___/___)		
4. Information to be released:		
_____ Clinical chart notes	_____ Hospital Records	_____ Laboratory Reports
_____ Pathology Reports	_____ Diagnostic Imaging	_____ EKG
_____ Radiology Reports	_____ Other	
5. HIV TESTING: Requires a separate specific signature. By signing below, I authorize the release of HIV related testing. This information will not be released without this separate signature.		
Signature: _____		Date: _____
6. MENTAL HEALTH: Requires a separate specific signature. By signing below, I authorize the release of Mental Health records. This information will not be release without this separate signature.		
Signature: _____		Date: _____
7. This authorization expires: (___/___/___) If not noted, this request expires in 180 days.		

**PLEASE CONTINUE TO THE OTHER SIDE OF THIS FORM
TO PROVIDE AUTHORIZATION SIGNATURE**

- Information related to alcohol or drug abuse treatment, psychiatric counseling or genetic testing should be requested from the facility that provided these services.

- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. I understand that federal or state law may restrict re-disclosure of HIV/AIDS information. I release Doctor's Family Clinic & Immediate Care, its employees and physicians from all liability arising from this disclosure of my health information.

- Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization necessary to make that disclosure.

- If you request a copy of your medical information we may charge a fee for the costs of copying, mailing or other associated supplies. **ORS 192.521. DFCIC charges are as follows: \$25.00 for 10 or fewer pages of written material and 25 cents for each additional page.**

- We are allowed 30 days to process your request. We will attempt to process your request sooner, however your request will be processed in the order it is received and the urgency of other requests.

- You may revoke this authorization in writing at any time. Please notify, in writing, the Medical Records Department, knowing that previously disclosed information is not subject to this request.

**I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I THEREBY
REQUEST THAT MY RECORDS BE RELEASED AS DIRECTED.**

Signature Of Patient or Personnel Representative

DATE

Please mail these records.
Please hold these records for pick-up.

FOR OFFICE USE ONLY

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|----------------------------|--------------------------|
| 1. Date Received: _____ | 2. Date Processed: _____ |
| 3. Processed By: _____ | 4. Date Mailed: _____ |
| 5. Date Scanned: _____ | |
| 6. Request Reviewed: _____ | 7. Request Denied: _____ |

Comments: _____
