AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION

The Corvallis Clinic

Please mail or fax completed form to: Health Information/Release of Records, 444 NW Elks Drive, Corvallis, OR 97330 Phone: 541-768-2368 | Fax: 541-753-1966 | www.corvallisclinic.com

Patient name: _____ Other names used: _____
Current address: _____ Date of birth: _____
Daytime phone: _____ Home phone: _____ Last four digits of SSN: _____

1. Purpose of Release Request

❑ Verbal release between parties in #3 & #4 Relationship to patient: ……

2. Type of General Medical Information to be Verbally Released/Discussed:

❑ Complete medical record. This will include radiology and mental health records.
❑ Specialty Behavioral Health Department records
❑ Physician notes and records (limited to two (2) years of information and mental health and mental health diagnosis
❑ Lab test results. Please specify tests and their dates _____
❑ Imaging reports (X-ray, MRI, etc.) Please specify dates _____
❑ Electrocardiogram (ECG/EKG) reports
❑ Vaccine and medication record
❑ Problem list
❑ Operative records (procedures done at The Corvallis Clinic)
❑ Health information summary; dates……..
❑ Billing
❑ Other records or test results.

Please specify information and dates: _____

By placing my initials on any of the below listed items, I hereby agree to their release:

…… **HIV/AIDS Information**

…… **Genetic Information**

…… **Drug/Alcohol**

Release of the above information is limited to the following time frame or treatment dates:

……

3. I authorize the information designated above to be released from:

❑ The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility, person, or provider: _____
Fax number: _____
Email: ……
Street address: _____
City/State/Zip: _____

4. I authorize the information designated above to be released to:

❑ The Corvallis Clinic, P.C.

If other than The Corvallis Clinic, please be complete and specific:
Name of facility or person: _____
Fax number: ……
Email: _____
Street address: _____
City/State/Zip: _____

5. Expiration of Authorization of Release (Required)

This authorization is valid for 90 days from the date of the authorization or until (specify date) ___/___/____ unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting the HIPAA Privacy Officer, 444 NW Elks Drive, Corvallis, OR 97330, telephone 541-754-1374. The only exception is when The Corvallis Clinic has already acted in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

6. Disclosure & Authorization Signature (Required)

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of The Corvallis Clinic or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

Signature of patient (or legally responsible person)-state relationship to patient **Date**