PERMISSION TO RELEASE MEDICAL RECORDS AND MEDICAL INFORMATION

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

- ❑ Changing Doctors
- ❑ Legal Reasons
- ❑ Doctor Consultation/Referral
- ❑ Self-use
- ❑ Moving outside the area
- ❑ Verbal Release between Parties in **#3** & **#4**
- ❑ Other: Please specify____________________

2. Type of General Medical Information to be Released

- ❑ Complete Copy of all Medical Records (includes radiology and billing)
- ❑ Physician notes and records (limited to two (2) years of information and excludes other protected records)
- ❑ Lab test results. Please specify tests and their dates____________________
- ❑ Imaging reports or CD (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
- ❑ Other records or test results.

Please specify information and dates:____________________

- ❑ Appointment times
- ❑ Billing

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information**.

________**Mental Health** Information
________**Drug/Alcohol** Conditions
________**HIV/AIDS** Information
________**Genetic** Information

Release of the above information is limited to the following time period or treatment dates:
____
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Treatment dates____________________
____
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3. I authorize the information designated above to be released from

(Please be complete and specific)
Name of Facility, Person, or Provider:____________________
Fax Number: ____________________
Street Address:____________________
City/State/Zip:____________________

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

Name of Facility or Person:____________________
Fax Number: ____________________
Name of Provider or Department (Required):____________________
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 taken action 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.

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