

Patient Name: _____ Medical Record #: _____
Address: _____ Date of Birth _____
City/State/Zip _____ Phone: _____

Please RELEASE Information FROM:

Please RELEASE information TO:

Name

Street Address

City/State/Zip

Telephone Number

Fax Number

Name

Street Address (or specified fax number)

City/State/Zip

Telephone Number

Fax Number

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

For the Purpose of: Patient Care Insurance Claim Self Other _____

List specific dates of records to be released: _____

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows:
_____ (date or event.)

The following must be INITIALED by the requestor to be included in the use and/or disclosure:
_____*HIV/AIDS related information and/or records _____Mental Health Information
_____*Genetic Testing information _____**Drug/alcohol diagnostics, treatment, or referral information
***This information may not be re-disclosed without the specific written authorization of the individual, except where authorized by law.**
****Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.**

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see back of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see back of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: _____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: _____

Adventist Medical Center, Portland, Oregon

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION: OREGON**

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Authorization to Release Medical Info

46096 Rev. 2/08
Legal Docs

Retain in Patient Record

For Office Use Only

Date Received: _____ Date Information Released: _____

Copy of verification of identity of individual and/or legal representative obtained/filed.

Notes: _____

Medical Record Number

Clerk Initials

Revocation of Authorization

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

- Above Authorization
- Authorization releasing information to _____
- Authorization dated _____

Signature: _____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: _____

For Office Use Only

Date Revocation Received: _____

Medical Record Number

Clerk Initials

Exceptions:

The exceptions noted in the Rights section on front of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.

Adventist Medical Center, Portland, Oregon

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION: OREGON**

