PENDLETON FAMILY MEDICINE

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AUTHORIZATION TO DISCLOSE INFORMATION

This authorization must be written, dated, and signed by the patient or by the person authorized by law to give authorization.

Name **Date of Birth** **Phone Number** **Relationship**

_____

_____

_____

By INITIALING the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____Medical records needed for continuity of care (Chart notes, labs, x-rays, pathology and special tests)
_____Most recent chart notes (Chart notes, labs, x-rays and special tests)
_____All hospital records (including nursing records and progress notes)
_____Emergency and urgency care records

_____Laboratory reports
_____Diagnostic imaging reports
_____Pathology

_____Specific information (please specify):_____

***Must be initialed to be included in other documents.**
_____*HIV/AIDS related records
_____*Mental health information
_____*Genetic testing information
_____ *Drug/alcohol diagnosis, treatment, or referral information

_____This authorization is limited to the following treatment _____
_____This authorization is limited to the following time periods_____
_____This authorization is limited to a workers' compensation claim for the date of injury_____

This authorization shall be in force and effect until such a time as Pendleton Family Medicine no longer maintains the health information or until revoked by the undersigned in the manner described below, or until [insert applicable date or event, ie death] _____

_____ _____
(Signature of Patient) **(Date)**

_____ _____
(Signature of person authorized by law) **(Date)**