PENDLETON FAMILY MEDICINE

2450 SW Perkins Avenue
Pendleton, Oregon 97801
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Print patient name_____ Date of birth_____

Address, city, state, zip code_____

Patient phone number_____ Patient insurance company_____

I hereby authorize the release of medical information regarding the patient named above by copy of medical records and/or by discussing the information in person or by phone.

From (Facility/Physician/Individual):_____

Address _____ (Phone) _____

City, State, Zip Code_____ (Fax) _____

To: Pendleton Family Medicine
2450 SW Perkins Avenue
Pendleton, OR 97801
Phone: 541-276-1700 Fax: 541-276-6327

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
_____Specific information (please specify):_____

_____Laboratory reports
_____Diagnostic imaging reports
_____Pathology

***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 _____ALL_____
_____This authorization is limited to the following time periods _____ALL_____
_____This authorization is limited to a workers' compensation claim for the injuries of_____

This authorization may be revoked at any time. The only exception is when action had been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in one (1) year from the date of signing and shall remain in effect for the period reasonably needed to complete the requirement.

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

_____ _____

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