Canyon Medical Center

**RELEASE OF MEDICAL RECORDS REQUEST**

*This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Canyon Medical Center does not offer reimbursement for records received.*

Patient Name (Please Print): _____ DOB: _____

Address _____

Phone _____ Parent or Guardian: _____

**RELEASE TO:**

- ☐ Canyon Medical Center
- ☐ SELF
- ☐ Other Clinic

  Name _____

  Address_____

  Phone _____ Fax _____

**RELEASE FROM:**

- ☐ Canyon Medical Center
- ☐ Clinic or physician

  Physician and Clinic _____

  Address_____

  Phone _____ Fax _____

********** Please release the following information: **********

*By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:*

_____ All Medical Records Necessary for the Continuity of Care

_____ Labs and Diagnostic Imaging Only

_____ Other: _____

**Patient Signature: _____ Date: _____**

**Parent/Guardian Signature (if applicable):_____ Date: _____**

********** Confidential Information **********

*I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Canyon Medical Center. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:*

_____ HIV/AIDS test results and related information, including high-risk behavior documentation.

Patient Signature

_____ Drug/Alcohol diagnosis, treatment, or referral information.

Patient Signature

_____ Mental Health information.

Patient Signature

**Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:**

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## Please mail or fax to:
## Canyon Medical Center
## 503-256-8422

2100 SW Camelot Court Portland, OR 97225 P: (503) 252-8125 F: (503) 256-8422

Canyon Medical Center

**CONSENT TO DISCLOSE MEDICAL INFORMATION**

Patient Name (Please Print): _____ DOB: _____

**Authorized Individuals:**

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

I HAVE AGREED TO LET CERTAIN INDIVIDUALS PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE. THEREFORE, I HEREBY GIVE MY PERMISSION FOR CANYON MEDICAL CENTER TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED ABOVE.

PLEASE INITIAL DISCLOSURE BELOW:

- ☐ CANYON MEDICAL CENTER MAY DISCLOSE MY MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED WHEN I AM NOT PHYSICALLY PRESENT, INCLUDING DISCLOSURES BY TELEPHONE, FACSIMILE, E-MAIL OR REGULAR MAIL
- ☐ REFILL/PICK-UP MEDICATIONS
- ☐ CALL FOR MEDICAL ADVICE
- ☐ SCHEDULE/CANCEL APPOINTMENTS
- ☐ PICK-UP COMPLETED FORMS

(CANYON MEDICAL CENTER WILL NOT DISCLOSE CONFIDENTIAL INFORMATION UNLESS MEDICALLY NECESSARY)

PLEASE INITIAL BELOW TO AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

- ☐ ALCOHOL/DRUG ABUSE EVALUATION/TREATMENT
- ☐ HIV/AIDS/STD EVALUATION/TREATMENT
- ☐ PSYCHIATRIC/MENTAL HEALTH EVALUATION/TREATMENT

- ☐ **I REFUSE DISCLOSURE TO ANY AND ALL PARTIES**

I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME BY WRITTEN NOTICE TO CANYON MEDICAL CENTER.

**Patient Signature:** _____ **Date:** _____

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