



RETURN THIS FORM TO RELEASE OF INFORMATION [ROI] AT THE SOUTH OFFICE 6640 SW REDWOOD LANE, PORTLAND OR 97224 OR FAX TO 503-620-5348

Authorization to Release Medical Information from The Portland Clinic

Patient Name _____ DOB _____ Former Name _____

Current Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening phone _____ SS# _____

I authorize information to be sent to:

Physician/or Other Third Party Named

Address

City, State, Zip

Purpose of Release: check one box

- Changing Primary Care Physician/Clinic *
- Referral/Consultation *
- Insurance **
- Legal **
- Personal Use/Other **

* Records sent to outside physicians/clinics are provided as a courtesy.
** Fees may apply: the rate is \$25 for the first 10 pages and .25 cents each additional page plus postage.

INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW

General Medical Records - excluding protected records. Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and immunizations. Please contact the Release of Information office directly if additional information is needed.

-OR-

Specific Information Only:

- History and Physical Specify Date _____
- Medications/Therapy
- Lab, Pathology, EKG Specify Type or Date _____
- X-ray Reports
- Films Type _____ Date Taken _____ Report _____
- Operative Report Specify Type or Date _____
- Accident or Injury Dates From _____ To _____
- Immunizations Only
- Other

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.

INITIAL DRUG ABUSE DIAGNOSIS/TREATMENT

INITIAL SEXUALLY TRANSMITTED DISEASES

INITIAL ALCOHOLISM DIAGNOSIS/TREATMENT

INITIAL AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR

INITIAL MENTAL HEALTH/TREATMENT

INITIAL GENETIC TESTING

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

Signature of Patient or Legally Responsible Person

Relationship to Patient

Date