HOLY FAMILY CATHOLIC CLINIC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

21810 Willamette Dr, West Linn, OR 97068 & 1829 NW Kings Blvd, Corvallis, OR 97330
Phone: (503) 994-4353 // **Fax**: (833) 975-0942

Patient Name: _____ Other Names Used: _____

Current Address: _____ Date of Birth: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Last four digits of SSN:_____

Types of General Medical Information to be Released:

☐ All Clinician(s) Chart Notes
☐ Problem List
☐ Most Recent Chart Note(s) for each chronic condition
☐ Hospital Discharge Summary
☐ Medications/Therapy
☐ Immunizations
☐ Diagnostic Reports (EKG, Radiology, EMG, etc.)
☐ Operative Reports
☐ Imaging Reports
☐ Lab/Pathology ECG Reports
☐ History & Physical
☐ Specialist Consultations
☐ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.**

x_ _ _ _ **Mental Health** Information
x_ _ _ _ **Drug/Alcohol** Conditions
x_ _ _ _ **HIV/AIDS** Information
x_ _ _ _ **Genetic** Information

I authorize a copy of my information be released from:

Name of Facility, Person, or Provider: _____

Street Address: _____

City/State/Zip: _____

Fax Number: (_____) _____

I authorize a copy of my information be released to: **Holy Family Catholic Clinic, P.S.**
1829 NW Kings Blvd.
Corvallis, OR 97330
Fax #: (833) 975-0942

Expiration of Authorization of Release
This consent is valid for one year from the date of signing. I understand that this authorization may be revoked in writing at any time by providing a written statement to the address above. No revocation will be retroactive to pertain to records already released.

Disclosure & Authorization Signature (Required)
I understand that my establishing or receiving medical care is NOT contingent upon signing this form. I understand the release of this information is intended to assist the physician at Holy Family Catholic Clinic, P.S. (HFCC) to care for the patient indicated above. I understand that the information used or disclosed may be subject to re-disclosure except for highly confidential information to include "sensitive" information shown above. I desire to release the medical information for the patient indicated above for the purposes of establishing and coordinating care and updating records maintained at HFCC. The undersigned hereby releases HFCC. from any liability which may arise from the release and/or examination of the information indicated above. I have read this authorization, and I understand it.

_____ _____

Signature of Patient or Legal Representative *Date*