2480 Liberty Street NE, Suite 180, Salem, OR 97301
Office: (503) 371-1010 Fax: (503) 371-0805

This authorization must be filled-out, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize_____ to release a copy of the medical information for
_____ (Name of Patient)
to_____ (Name of Recipient)
Mailing Address_____or Fax Number _____

The information will be used on my behalf for the following purpose(s):
_____

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

____ All hospital records (including nursing records and progress notes)
____ Transcribed hospital reports
____ Medical records needed for continuity of care
____ Most recent five year history
____ Laboratory reports
____ Pathology reports
____ Diagnostic imaging reports
____ Clinician office chart notes
____Dental records
____Physical Therapy records
____Emergency and urgency care records
____Billing Statements
____Other

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

____ *HIV/AIDS-related records
____*Genetic testing information

*Must be specifically selected to be included in other documents.

____**Drug/Alcohol diagnosis, treatment or referral information _____

**Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

____ This authorization is limited to the following treatment: _____
____ This authorization is limited to the time period: _____
____ This authorization is limited to a worker's compensation claim for injuries of:_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization, unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of patient)

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