The Oregon Clinic Authorization to Obtain Medical Records

Which facility/what doctor are you requesting records from?

Facility/Dr. Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Which location/provider of The Oregon Clinic should receive these records?

Facility/Dr. Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like obtained?

Specific Categories

□ All Records □ All Records *(within the last 6 months)* □ Office/Clinic Notes □ Operative Reports

□ Lab/Pathology Results □ Imaging Reports □ Hospital Records

□ Dates: *From:* _____*To:*_____ □ Other_____

Your medical records may include sensitive material. Please **initial** the categories listed below if you would like them included.

___ Substance Abuse, if any ___ AIDS/HIV/STDs, if any ___ Psychological/Psychiatric conditions, if any ___ Genetic Testing, if any

Why are we sending the records?

Purpose of Disclosure

□ Personal Use □ Litigation/Legal □ Disability □ Insurance □ Transfer/Continuation of Care

Patient's signature*

Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age child; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient. *The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.* This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and will no longer be protected by federal regulations.

Patient's/Authorized Rep of Patient's Signature: Date:

Relationship to Patient:

Please send completed form directly to the clinic for processing. For assistance, please call the Information Line at 503-935-8000.