AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

I AUTHORIZE:

_____

Name of provider, facility, or individual that will SEND information

_____

Street Address

_____

City State Zip Code

(_____)_____(_____)_____

TO RELEASE TO:

Advanced Internal Medicine

9555 SW Barnes Rd Suite 255
Portland, Or 97225
Phone: (503) 908-1590 | Fax: (503) 723-2862

INFORMATION TO BE RELEASED: (Check all that are applicable)

□ All Information □ All Progress Notes □ Lab Reports □ Imaging Reports

□ Electrocardiogram (EKG) □ Allergy Records □ Immunization Records □ Other: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By checking the appropriate boxes and signing below, you authorize the office to release any and all information regarding:

□ Alcohol □ Drugs □ Mental Health □ Sexually Transmitted Diseases □ HIV/AIDS

Signature:

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RECORDS FROM THE PERIOD: _____/_____/_____ to _____/_____/_____ or □ **ALL DATES**

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

□ Continued Medical Care □ Payment of Insurance Claim □ Legal □ Personal □ Other: _____

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

PATIENT SIGNATURE:

DATE of REQUEST: ____/____/_____

AIM Health