AUTHORIZATION TO RELEASE AND DISCLOSE MEDICAL INFORMATION

Patients Name: _____

Date of Birth: _____ Home Phone: _____

I Authorize The Following:
(Complete Address)

_____

_____

_____

Phone: _____

To Provide Information To:

Pacific Family Medicine, LLP
2055 Exchange St., Suite 190
Astoria, OR 97103
503-325-5300 (Fax) 503-325-5400

The specific health care information to be used / disclosed consists of:

□ Chart Notes □ Lab / X-ray Reports □ Other _____

□ All Health Care Information (I understand this information may be voluminous and agree to pay all reasonable charges associated with providing this information.)

The information is requested for the following reason:

□ Permanent Transfer □ Insurance Purposes □ Legal Purposes □ Personal Use
□ 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.

____ HIV / AIDS Information
____ Genetic Testing
____ Mental / Behavioral Health Information
____ Drug / Alcohol Diagnosis, Treatment, Referral

You do not need to sign this Authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

The recipient of these records cannot transfer them without expressed consent from the patient or authorized guardian. This authorization is valid for 90 days only and subject to revocation at any time, except to the extent that action has been taken in reliance upon this consent before written notice of revocation was received.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Printed Name of Patient's Representative

_____
Description of Personal Representative's Legal Authority