

SILVERTON SPECIALIST
 452/454 Welch St. • Silverton, OR 97381
 503-874-2424 • Fax 503-874-2446

TUKWILA SPECIALIST
 693 Ray J. Glatt Circle • Woodburn, OR 97071
 503-982-4878 • Fax 503-982-4898

WELLSPRING SPECIALIST CENTER
 1475 Mt. Hood Avenue • Woodburn, OR 97071
 971-983-5252 • Fax 971-983-5253

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize that the MEDICAL RECORDS listed below for the care and treatment of myself (or the identified MINOR CHILD for whom I have responsibility) be provided as indicated and for the purposes specified.

Signature: _____ Print Name _____ Date _____

REASON FOR THE RELEASE OF THESE RECORDS:			
<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Referral	<input type="checkbox"/> Reimbursement	<input type="checkbox"/> Employment <input type="checkbox"/> Specialist
NAME OF PATIENT (F, M, L)	SEX M F	DATE OF BIRTH	SOC. SEC. NO.
ADDRESS			DAYTIME PHONE
RECORDS TO BE RELEASED (cross out those that do not apply):			
Chart Notes	X-ray Reports / Films	Dental Records	
Laboratory Results	History / Physical Exams	Consult Reports	
Medication Records	Treatment Records	Other: _____	
These records require specific authorization and may require special handling.			
Initial by responsible party indicates authorization of release of particular additional confidential information within the limits specified:			
_____ HIV / AIDS-related Records	_____ Mental Health Records		
_____ Genetic Testing Records	_____ Drug / Alcohol Treatment Records		
Specify how much information: _____			
Specify what kind of information: _____			
Specify the time period: from _____ to _____			
RECORD RELEASE INSTRUCTIONS (circle)			
FROM	TO	FROM	TO
<input type="checkbox"/> SILVERTON SPECIALIST 503-874-2424		Doctor: _____	
<input type="checkbox"/> TUKWILA SPECIALIST 503-982-4878		Phone	Fax
<input type="checkbox"/> WELLSPRING SPECIALIST CENTER 971-983-5252			
Name: (Please print) _____			
Signature: _____		Date: _____	
If this authorization is signed by a personal representative on behalf of the individual, complete the following:			
Personal Representative's Name: _____			
Relationship to Individual: _____			
I recognize that healthcare records contain confidential information that is protected by policy, custom and state and federal laws. I understand that this information will be sent by mail or FAX. I understand that this is not a blanket authorization and that it can be revoked at any time with the exception of actions taken when the authorization was in effect. I understand that this authorization is for the stated purposes only and will remain in effect only for a period of time adequate to accomplish those purposes.			
I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Silverton Specialist, 452/454 Welch St., Silverton, OR 97381 or Tukwila Specialist, 693 Ray J. Glatt Circle, Suite 4, Woodburn, OR 97071 or Wellspring Specialist Center, 1475 Mt. Hood Avenue, Woodburn, OR 97071 . I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.			
I understand that once the information is disclosed pursuant to this authorization it may be redisclosed by the recipient and the information may not be protected by federal privacy regulation.			
I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.			
I understand that I will be given a copy of this authorization form, after signing.			
Signature X _____		Date _____	

COMPLETE AND ROUTE: WHITE - mail YELLOW - tracer PINK - medical record