**To Request Records to Our Clinic**

**Willamette Valley Orthopedic & Sports Medicine**
**2700 SE Stratus Avenue, Suite 303**
**McMinnville, OR 97128**
**Phone: 503-435-4520 Fax: 503-474-9430**

# Medical Record Release Form

## PLEASE FORWARD RECORDS TO: Willamette Valley Orthopedic & Sports Medicine Fax: 503-474-9430

**FACILITY/PROVIDER AUTHORIZED TO MAKE DISCLOSURE:**

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

**PATIENT IDENTIFICATION**

Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____

_____

**PURPOSE OF REQUEST**

□ Treatment or consultation

□ At the request of the patient

□ Billing or claims payment

□ Other: _____

**TYPE OF INFORMATION TO BE RELEASED**

□ Chart notes
□ Procedure report
□ Immunization records
□ Prescription/Medication records
□ History & Physical exam
□ Consultation reports
□ Laboratory test results
□ Radiology reports

Other: _____

**Time Limit & Right to Revoke Authorization**
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer. Unless revoked, this authorization will expire in 180 days or on the following date/event: _____.

**Release of Specially Protected Health Information**
I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. □ **YES** □ **NO** _____**Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. □ **YES** □ **NO** ____ **Initials**

**Disclosures**
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure**
I understand that Willamette Psychiatry may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
**I authorize Willamette Psychiatry to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Relationship if not the patient: _____