

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 authorization 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: _____

CONFIDENTIALITY NOTICE

This document contains confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please place it in an envelope to protect its confidentiality (without reviewing it) and call us for instruction on its disposal.