MEDICAL RECORDS RELEASE AUTHORIZATION

1234 COMMERCIL ST SE

PHYSICIANS' BUILDING GROUP **SALEM, OREGON 97302**

Phone 503 362-9334
Fax 503 362-8016

TO:

_____
Name of Doctor/Facility obtaining records from

_____
Address

_____
City State Zip

I hereby authorize and request that you release to:

_____
Name of Doctor/Facility

_____
Address

_____
City State Zip

Reason for requesting records: _____

The complete history records in your possession concerning my illness and treatment during the period from _____ to _____. By INITIALING, I specifically authorize the release of the following confidential information:

_____ *HIV test/test results and related information including high risk behavior documentation

_____ *Drug/Alcohol diagnosis, treatment or referral information

_____ *Mental health treatment information

_____ *Other (specify) _____

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 12 months from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

PRINT PATIENT NAME: _____

PREVIOUS/OTHER NAMES: _____

DATE OF BIRTH: _____ SOC. SEC. NO. _____

PATIENT ADDRESS:_____

RELATIONSHIP (IF OTHER THAN PT.)_____ TELEPHONE NO: _____

SIGNATURE:_____ DATE:_____

* This form is intended to comply with the requirements of 42 CFR 2.31, which restricts the disclosure of information relating to alcohol or drug treatment unless authorized by the patient and with ORS 433.045 (3) and OAR 33312 270. Consent to HIV test required.