orchidhealth
Exceptional, local healthcare

Medical Records Release

Patient Name_____ Former Name (if any) _____

D.O.B.: _____ Phone: _____

Address _____ City _____ State _____ Zip

I authorize information to be released FROM:

Name/Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____

I authorize information to be released TO:

Name/Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____

The purpose of this request is:

☐ Referred Medical Care ☐ Transferring Care ☐ Personal ☐ Legal ☐ Other _____

Type of information to be released:

☐ Complete Medical Records *(Consists of the last 2 years of treatment unless otherwise specified)*

☐ Other (Please specify): _____

MUST be INITIALED to be included with records

_____ HIV/AIDs related records _____ Mental Health related records _____ Genetic testing information

_____ Drug/Alcohol** ***PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

All records will be sent though fax unless otherwise indicated. I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

My signature indicates that I authorize the disclosure of the above information and understand the following:
I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment.
I understand I can cancel permission to use and disclose my information at any time in writing. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
I understand this change will not affect information that has already been shared.
I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/ AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.
I understand that I am allowed to receive a copy of this Authorization.

_____ _____ _____

Signature of Patient/Legally Responsible Person Relationship to Patient Date

☐ **Wade Creek Clinic**
535 NE 6th Ave • Estacada, OR 97023
F: (866) 669-3334 Ph: (503) 630-8550

☐ **Oakridge Clinic**
47815 Hwy 58 • Oakridge, OR 97463
F: (855) 313-2095 Ph: (541) 782-8304

☐ **Fern Ridge Clinic**
24934 Fir Grove Ln • Elmira, OR 97437
F: (833) 673-0252 Ph: (541) 234-3255

☐ **McKenzie River Clinic**
54771 McKenzie Hwy • Blue River, OR 97413
F: (833) 905-2303 Ph: (541) 822-3341

☐ **Sandy Clinic**
37400 Bell St • Sandy, OR 97055
F: (833) 903-3607 Ph: (971)220-2701

☐ **Hoodland Clinic**
24461 E Welches Road • Welches, OR 97067
F: (833) 973-4292 Ph: 971-333-0494