FAMILY MEDICAL GROUP OF SILVERTON

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(503)873-8686 (phone)
(503)873-8689 (fax)

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____ to release a copy of the medical information for :

_____

to:(please circle one) Robert Rosborough, MD Nathan Bay, MD

Shandra Greig, MD Denise Taylor, MD Kelsey Hupp, FNP,DNP

Katie Houts, MD Elizabeth Blount, MD Phil Hellman, MD

The information will be used on my behalf for the following purpose(s):_____

By marking the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____	All hospital records	____	Clinician office chart notes
____	Transcribed hospital reports	____	Diagnostic imaging reports
____	Records needed for continuity of care	____	Dental records
____	Laboratory reports	____	Physical Therapy records
____	Pathology reports	____	Billing Statements
____	Most recent five year history		
____	Other: _____		
____	Please send entire medical record (all information) to the above names recipient.		

INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:

___	HIV/AIDS related records	___	Mental health information
___	Genetic testing information	___	Drug/alcohol diagnosis, treatment or referral information

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release Family Medical Group, its employees, and providers from all liability arising from this disclosure of my health information.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. 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. A copy of this authorization will have the same effect as an original.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

PRINT NAME of PATIENT: _____DATE: _____

DOB OF PATIENT:_____ SSN:_____

SIGNATURE:_____ Relationship to Patient_____