

Rehabilitation Medicine Associates, P.C.
1040 NW 22nd Ave., Suite 320 • Portland, OR 97210 • 503-413-6294 Office • 503-413-7780 Fax
Authorization for Release of Health Care Information

Patient Information (Please Print):

Name: _____ Date of Birth _____ SS # _____

Information to be release from: _____

(Name of Designated Facility or Provider)

(Address)

(City, State and Zip Code)

Information to be sent to: _____

(Name of Designated Recipient)

(Address)

(City, State and Zip Code)

Information to be Released:

- The most recent 2 years of pertinent information (Chart Notes, Labs, X-Rays and Special Tests)
- All Medical Records
- Specific Information (Please Specify): _____

Purpose for which Disclosure is Being Made: (Please Check One of the Following)

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** Exclude the following information from the records released (please initial):**

____ Drug/Alcohol abuse/treatment & diagnosis	____ Sexually Transmitted Disease
____ HIV/AIDS diagnosis/treatment & testing	____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patient posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may not longer be protected under privacy laws.

Signature _____ Date _____
(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of the patient.]

This authorization will expire in 1 year from the date signed.

Possible Copying Fee Required