AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RECORDS

Sunset Family Health Center
10395 NW Glencoe Road, Suite 200
North Plains, Oregon 97133
Phone (503) 647 - 9400
Fax (503) 647-5120

I hereby authorize:

Name of person or group releasing records:
Address:
Phone and fax numbers:

To provide medical information to:

Name of person or group receiving records:
Address:
Phone and Fax Numbers:

Patient Name: (please print) _____

DOB:_____

Please Release (please circle one): ENTIRE RECORD ONLY THE INFORMATION INDICATED BELOW

_____

_____

For the purpose of: _____

Permission to fax and or send Electronically? Yes No

ALL FAXED MATERIAL WILL CONTAIN A CONFIDENTIALITY STATEMENT; HOWEVER, I UNDERSTAND CONFIDENTIALITY AT THE RECEIVING END CAN NOT ALWAYS BE ASSURED.

I AUTHORIZE THE DISCLOSURE OF MY MEDICAL RECORDS FOR THE PURPOSE STATED ABOVE. I FURTHER UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN ON THIS AUTHORIZATION.

_____ _____

Patient signature (DATE) Parent/legal guardian signature (DATE)

This release is effective for six months from the date it is signed, or expires on: _____

Permission to release sensitive information:

____HIV test and test results, and related information including high risk behavior documentation
____Drug/Alcohol diagnosis, treatment or referral information
____Mental health treatment information
____Genetic information

_____ _____

Patient Signature (DATE) Parent/legal guardian signature (DATE)