❑ **SILVERTON SPECIALIST**
452/454 Welch St. • Silverton, OR 97381
503-874-2424 • Fax 503-874-2446

❑ **TUKWILA SPECIALIST**
693 Ray J. Glatt Circle • Woodburn, OR 97071
503-982-4878 • Fax 503-982-4898

❑ **WELLSPRING SPECIALIST CENTER**
1475 Mt. Hood Avenue • Woodburn, OR 97071
971-983-5252 • Fax 971-983-5253

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize that the MEDICAL RECORDS listed below for the care and treatment of myself (or the identified MINOR CHILD for whom I have responsibility) be provided as indicated and for the purposes specified.

Signature: _____ Print Name _____ Date _____

REASON FOR THE RELEASE OF THESE RECORDS:

❑ Continuity of Care ❑ Referral ❑ Reimbursement ❑ Employment ❑ Specialist

NAME OF PATIENT (F, M, L)	SEX M F	DATE OF BIRTH	SOC. SEC. NO.
ADDRESS			DAYTIME PHONE

RECORDS TO BE RELEASED (cross out those that do not apply):

Chart Notes	X-ray Reports / Films	Dental Records
Laboratory Results	History / Physical Exams	Consult Reports
Medication Records	Treatment Records	Other: _____

These records require specific authorization and may require special handling.
Initial by responsible party indicates authorization of release of particular additional confidential information within the limits specified:

_____ HIV / AIDS-related Records _____ Mental Health Records

_____ Genetic Testing Records _____ Drug / Alcohol Treatment Records

Specify how much information: _____

Specify what kind of information: _____

Specify the time period: from _____ to _____

RECORD RELEASE INSTRUCTIONS (circle)

FROM TO	FROM TO
❑ **SILVERTON SPECIALIST** 503-874-2424 ❑ **TUKWILA SPECIALIST** 503-982-4878 ❑ **WELLSPRING SPECIALIST CENTER** 971-983-5252	Doctor: Phone Fax

Name: (Please print) _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

I recognize that healthcare records contain confidential information that is protected by policy, custom and state and federal laws. I understand that this information will be sent by mail or FAX. I understand that this is not a blanket authorization and that it can be revoked at any time with the exception of actions taken when the authorization was in effect. I understand that this authorization is for the stated purposes only and will remain in effect only for a period of time adequate to accomplish those purposes.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to **Silverton Specialist, 452/454 Welch St., Silverton, OR 97381** or **Tukwila Specialist, 693 Ray J. Glatt Circle, Suite 4, Woodburn, OR 97071** or **Wellspring Specialist Center, 1475 Mt. Hood Avenue, Woodburn, OR 97071.** I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the information is disclosed pursuant to this authorization it may be redisclosed by the recipient and the information may not be protected by federal privacy regulation.

I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

I understand that I will be given a copy of this authorization form, after signing.

Signature X _____ Date _____

COMPLETE AND ROUTE: WHITE - mail YELLOW - tracer PINK - medical record