Southern Oregon Wellness Clinic
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Central Point, OR 97502
541-973-2551
541-973-2835
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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or person authorized by law to give authorization. *I hereby consent and authorize the release of medical information for:*

Patient Name: _____ **Date of Birth:** _____

FROM: _____ ***(Name of Clinic REQUESTING records from /Hospital/Address)***

_____ ***(Phone number and Fax number)***

TO: _____ ***(Name of Clinic TO SEND RECORDS to Phone number and/or Fax number)***

Purpose of Release: _____

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

_____ Full Medical Record **-OR-** _____ Last Two Years for Continuity of Care

_____ Emergency or Urgent Care Only _____ Pathology Reports Only

_____ Clinical Notes Only _____ Diagnostic Reports Only

_____ Billing Statements _____ Other (specify)

If the information to be disclosed contains any type of information listed below, additional laws related to the use and disclosure of the information may apply. I understand and agree this information will be disclosed if I place my **INITIALS** in the applicable spaces next to that type of information. **Southern Oregon Wellness** does **NOT** review for these items and requests ***MAY*** contain this information. Initialing will expedite this request but if desired, in lieu of initials, please provide the full mailing address of the patient and all records will be sent directly to the patient for release of these items as desired.

_____ HIV/AIDS Information _____ Genetic Testing _____ Mental Health Information
_____ Drug/Alcohol Diagnosis, Treatment or Referral Information

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on 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.

_____ _____
Signature of Patient Date Signature of Person Authorized by Law Date