AUTHORIZATION TO RELEASE MEDICAL RECORDS

West Linn Primary Care
18670 Willamette Drive, Suite 101
West Linn, Oregon 97068
Phone (503)636-1133 Fax (503)636-1331

Patient: **Social Security #:** **DOB:**

I authorize my records to be sent to:

West Linn Primary Care
18670 Willamette Dr., Suite 101
West Linn, OR 97068
Phone: 503-636-1133
Fax: 503-636-1331

I authorize my records to be released from:

Name of Provider:_____

Address:_____

City, State, Zip_____

Phone:_____

Fax:_____

By signing and checking the boxes below, I authorize the use and disclosure of the following medical information and/or medical records: This information will be sent via fax, computer, or mail to West Linn Primary Care:

- ☐ General medical records needed for continuity of care, including office chart notes and electronic medical records
- ☐ Hospital Records
- ☐ Physical Therapy Records
- ☐ Diagnostic imaging reports
- ☐ Lab/Pathology/EKG reports
- ☐ Medication/Immunization Records
- ☐ Other: _____

I understand that certain protected or sensitive information in these records cannot be released without specific authorization because of federal or state laws. By initialing below, I specifically authorize the release of the following confidential information:

_____HIV/AIDS Information _____ Mental Health Information

_____Drug/Alcohol diagnosis, treatment, or referral information _____Genetic testing Information

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure and no longer protected by Federal Law.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursements for services. The only circumstance when refusal to sign this authorization means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

This authorization is valid until revoked in writing. You may revoke this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposes described n this written authorization. The only exception is when WLPC has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to West Linn Primary Care, 18670 Willamette Dr., Suite 101, West Linn, OR 97068.

Patient Signature **Date**

Signature of Parent/Guardian if Applicable