8401 SE POWELL BLVD PORTLAND OR 97266
TEL: (503) 227-1222 FAX: (503) 227-1555
503 (c)(3) Tax ID # 76-0767257

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 authorize MERCY & WISDOM COMMUNITY HEALTH CLINIC to release a copy of the medical information for

_______________________________________ (name of patient) _______________ (date of birth)

to _______________________________________ (name of recipient).

This information will be used on my behalf for the following purpose(s): _______ continuity of care, or

______ other (specify): _______________________________________.

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

______ all hospital records (including nursing records and progress notes)
______ transcribed hospital reports
______ medical records needed for continuity of care
______ laboratory reports
______ most recent five year history
______ pathology reports
______ dental records
______ emergency and urgent care records
______ billing statements
______ physical therapy records
______ clinician office chart notes
______ other: _______________
______ diagnostic x-rays &/or imaging, including reports (current films only; please don't send films over 2 years old)

______ **Please send the entire medical record (all information) to the above recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.**

______ *HIV/AIDS-related records ______ *mental health information ______ *genetic testing information
*must be **initialed** to be included with other documents.

______ **drug/alcohol diagnosis, treatment, or referral information: _______________
**Federal Regulation 42 CFR, Part 2, requires a description of how much and what kind of information is to be disclosed.

______ This authorization is limited to the following treatment: _______________.
______ This authorization is limited to the following time period: _______________.
______ This authorization is limited to workers' compensation claim for injuries of (date) _______________;

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the 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 or _______________ Signature of Patient's Authorized Representative _______ Date

_______________ Name of Requesting Physician _______________ Signature of Requesting Physician

[outgoing records]