Lake Road Family Medicine
6564 SE Lake Rd. Ste 200
Milwaukie, OR 97222
Ph: 503-908-5880 Fax: 888-475-8729

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By **initialing** the spaces below, I, _____, DOB: _____ hereby authorize, Lake Road Family Medicine to: ***(please "X" appropriate line below)***
Release my records to: _____
Receive my records from: _____

Name of previous or new Provider/Clinic: _____ Phone: _____

Street: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Reason for requesting information: _____

By **INITIALING** the spaces below, I specifically authorize the release of the following medical records in my personal medical chart (if they exist)

____ **General Medical Records:** this excludes the protected records listed at the bottom of this page that requires specific authorization as required by State/Federal Law. Copies of medical records will be limited to two (2) years of information including progress notes, lab results, diagnostic imaging/testing reports and immunizations.

OR

Specific Information: These would be selected if you are only referring to *specific* records

____ History & Physical (specific date: _____)
____ Lab results/Pathology reports (specific type: _____)
____ Immunizations only
____ Accident or injury report (specific type & date: _____)
____ Other: (Please specify) _____
____ Medication List
____ Imaging reports
____ Billing statements

Protected or sensitive information: I understand certain information cannot be released without specific authorization as required by State/Federal Law. By **INITIALING**, I authorize the release of the following protected or sensitive information.

____ Drug abuse diagnosis/treatment
____ Alcoholism diagnosis/treatment
____ Mental health/treatment (i.e. anxiety & depression)
____ Sexually transmitted diseases
____ AIDS/HIV test results
____ Genetic testing

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on this authorization. Unless revoked earlier, this consent will expire in 180 days from the date of signing and shall remain in effect for the period reasonably needed to complete the request. By signing below, I authorize the use or disclosure of my protected health information as described above.

_____ _____ _____
Signature of Patient or Legal Responsible Person Relationship to Patient Date