River Road
Surgery Center

3099 River Road South, Suite 100 Salem, OR 97302 Phone: **503-361-3094** Fax: **503-485-2168**

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the release, use and/or disclose copies of my specific health and medical information identified below for the following purposes:

**Full name of patient:** _____ **DOB:** _____

Obtain records from: _____ Fax #: _____

Send records to: _____ Fax #: _____

Describe each purpose of disclosure /use: _____

☐ **Fax** ☐ **Patient Portal** ☐ **Given to Patient** ☐ **Call to pick-up Phone #** _____

☐ **Mail to:** _____

I specifically authorize the release, use of, and/or disclosure of the following health information and/or medical records, if such information and/or records exist. **INITIAL ALL THAT APPLY.**

_____ Entire medical records to the above named recipient.
_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five (5) year history
_____ Emergency and urgent care records
_____ Audiograms
_____ Clinician office chart notes
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Dental records
_____ Billing statements

* The following items must be initialed to be included in the use and/or disclosure of other health information:

_____*HIV/AIDS-related information and/or records
_____*Mental Health information and/or records
_____*Genetic testing information and/or records
_____*Drug / alcohol diagnosis, treatment, or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

- I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.
- I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
- Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or until (**insert applicable date or event**) _____

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

A copy of this signed form will be provided to the patient.

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

☐ **Completed by:**_____ ☐ **Faxed** ☐ **Portal** ☐ **Mailed** ☐ **Given to Patient** **Date:**_____