Canyon Medical Center

RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Canyon Medical Center does not offer reimbursement for records received.

Patient Name (Please Print): _____ DOB: _____

Address _____

Phone _____ Parent or Guardian: _____

RELEASE TO:

- ☐ Canyon Medical Center
- ☐ SELF
  - ☐ Email _____
  - ☐ Hard Copy- Available in Clinic only
- ☐ Other Clinic
  Name _____
  Address_____
  Phone _____ Fax _____

RELEASE FROM:

- ☐ Canyon Medical Center
- ☐ Clinic or physician
  Physician and Clinic _____
  Address_____
  Phone _____ Fax _____

********** Please release the following information: **********

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ All Medical Records Necessary for the Continuity of Care
_____ Labs and Diagnostic Imaging Only
_____ Other: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable):_____ Date: _____

********** Confidential Information **********

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Canyon Medical Center. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ HIV/AIDS test results and related information, including high-risk behavior documentation.
Patient Signature
_____ Drug/Alcohol diagnosis, treatment, or referral information.
Patient Signature
_____ Mental Health information.
Patient Signature

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

Please mail or fax ASAP to: Canyon Medical Center 503-256-8422

2100 SW Camelot Court Portland, OR 97225 P: (503) 252-8125 F: (503) 256-8422