2020 8th Ave., #200
West Linn, OR 97068
P: 503-512-1212
F: 503-512-1220

willamette PAIN & SPINE

10001 SE Sunnyside Rd. Ste, 100
Clackamas, OR 97015
P: 503-512-1212
F: 503-512-1220

Authorization to Release Information

All numbered entries MUST be completed

1. Patient Information:

Name: _____ DOB: _____

Address: _____

Phone: _____

2. I, the above named patient, authorize Willamette Pain and Spine to **RELEASE/RECEIVE** my medical records to/from:

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

3. Purpose of disclosure: ❑ Personal ❑ Legal ❑ Continuation of care ❑ Insurance

4. Information to be released: Treatment dates: _____ to _____

❑ Visit Notes/Summary ❑ Billing Records ❑ Lab reports ❑ Radiology/Imaging ❑ Emergency/Urgent Care

❑ Other: _____

❑	**I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV and AIDS, and treatment of alcohol and drug abuse.**

5. **Restrictions:** I understand that the information release may be subject to re-disclosure by the recipient and may no longer be protected. This authorization shall be in force and effect until _____ (date/event), at which time this authorization expires.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

6. _____

Patient/Legal Guardian Signature **Date** **Relationship to Patient**

This authorization will expire 6 months from the date of signing if not otherwise specified above.

For Office Use Only

Date Needed: _____

Provider: _____

Completed By: _____

❑Fee ❑ Fax ❑ Patient Pickup

❑Mail ❑ Email

Note:

RELEASE OF INFORMATION GUIDE

1. This field is for information regarding the patient whose records are to be released. You must provide AT LEAST the full name and date of birth. Please also include any other names the patient has used.

2. Enter the contact information for the outside provider/facility that you are asking to release or receive your records. Please provide as much information as you can *(first and last name, phone/fax number, address, etc)*.

3. Indicate the reason your records are to be released.

4. Describe, in as much detail as you can, the records you would like released. Also under #4 is a check box to release sensitive health and treatment information, if this box is not checked those records will not be released.

5. This release form automatically expires six months from the date of your signing; if you prefer you can input a specific date or event *(claim closure, treatment discharge, etc)* at which time your release will terminate.

6. Please sign and date your release. If someone other than the patient is signing the release please print your relationship to the patient.

If you have any questions regarding the completion of this form please contact the medical records department.