Dear Patient,

An **Authorization to Release Medical Information** form should be filled out when you would like a copy of your medical information to be sent to your new NWPC primary care provider or for personal use or when you need a copy of your child's medical information for personal use. This information is protected by HIPAA and will only be released with your permission.

In addition to your PCP records, please let us know if have had any of the following:

- Mammogram
- Pap Smear
- Colonoscopy
- Diabetic Eye Exam
- Bone Density Test

Instructions for completing NWPC Record Release Form:

(Important: any missing or inaccurate entries may delay or void your request)

- Photo ID may be required for patient/guardian verification
- Be sure to write legibly, to include:
  - Birthdate
  - Previous name (if any)
  - Where would you like the records sent (include address or fax number)
  - Why the records are being sent (purpose of release)
  - Type of information to be released (standard for "all records" is last two years of treatment unless specifically requested otherwise).
  - Patient/guardian signature and date
- If you want the information to be faxed, please mark on the form, "Permission to Fax". Please note that we will not fax any records that are more than 50 pages.
- Please allow 30 days for records to be sent as per Oregon State Law.

Who can receive copies of medical records:

Adult patients - Copies of their own medical records

Parent or Legal Guardian - Copies of their minor child's medical records

Legal Power of Attorney - Copies of the medical records of the person named in the power of attorney (for example; wife, husband or partner, disabled adult)

Authorization to Release Medical Information

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B _____
Street, City, State, Zip

Home Phone _____ Work Phone _____ S.S.# _____

I Authorize Information Released FROM: (Please Print)	**Please Send My Records TO:** (Please Print)
Name _____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____

Purpose of Release

☐ Dissatisfied with practitioner ☐ Moving ☐ Referral/Consultation

☐ Dissatisfied with staff ☐ Personal use ☐ Legal

☐ Transfer of care ☐ Insurance change ☐ Other _____

Permission to Fax Information: I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

I would like records sent via: ☐ CD (Adobe 8 or higher) ☐ Paper (***If not checked, CD is the default method.)***

Type of Information To Be Released

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

Protected or Sensitive Information: I understand that 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:

_____ Initial Drug/Alcohol Diagnosis/Treatment/Referral Information

_____ Initial Genetic Testing Information

_____ Initial Mental Health/Treatment

_____ Initial HIV/AIDS Information

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this authorization at any time, provided that you do so in writing to Northwest Primary Care Group. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

This authorization will expire in 180 days from the date of signing, or unless otherwise specified _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

BY: _____ DATE: _____
Patient or Patient Representative

Description of Representative's Authority: _____

☐ **Dwyer Clinic**
Internal Medicine
10024 SE 32nd Ave • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.654.5666

☐ **Milwaukie Clinic**
Family Medicine
3033 SE Monroe St • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.659.4730

☐ **Happy Valley Clinic**
Family Medicine
16144 Happy Valley Town Center, Building H
Happy Valley, OR 97086
PH: 503.659.4988 • FX: 503.698.4018

☐ **Oregon City Clinic**
Family Medicine
1511 Division St • Suite 102
Oregon City, OR 97045
PH: 503.659.4988 • FX: 503.353.1234

☐ **Sellwood Clinic**
Family Medicine
6327 SE Milwaukie Ave • Portland, OR 97202
PH: 503.659.4988 • FX: 503.353.1297

☐ **Medical Records**
12300 SE Mallard Way, Ste 160
Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.353.1293