



Northwest Health & Healing Center

1515 NW 9th St, Corvallis, OR 97330

(541) 754-2225 Fax: (541) 752-9086

Authorization to Disclose Medical Records

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ (Name of Clinic/HealthCare Provider)
to release a copy of my Medical Information for _____ (name of patient)

TO: _____ (name of recipient)

_____ (address)

The information will be used on my behalf for the following purpose(s): _____

_____ notes _____ Laboratory reports

_____ Most recent five year history _____ Diagnostic Imaging Reports

_____ Billing statements

_____ Other: _____

_____ Please send **my entire Medical Records** (all information) to the above named recipient. The recipient understands this record maybe voluminous and agrees to pay all reasonable charges associated with providing this record.

*The following items must be initialed to be included in other documents.

_____ **HIV/AIDS** related records

_____ Mental Health Information

_____ This authorization is limited to records regarding the following treatment: _____

Disclosure Statement:

I understand that once the information is disclosed pursuant to this authorization, I may be re-disclosed by the recipient without the knowledge or consent of Northwest Health & Healing Center, or you. This information may not be protected by Federal privacy regulation.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature: _____ Date: _____

Signature of person authorized by law: _____ Date: _____