

Bridge City Family Medical Clinic

Phone 503-460-0405

1410 NE 106th Ave, Portland, OR 97220

Fax 503-460-0434

Consent for Release of Protected Health Information

Patient Information

Name: _____ Date of Birth: _____

Street Address: _____ City _____ State _____ Zip _____

Also Known As: _____

I hereby authorize and give my permission to the providers/ individuals listed below to release and/or receive a copy of my record
(Circle which apply)

*****To Bridge City Family Medical Clinic From Bridge City Family Medical Clinic To Verbally exchange with *****
*****HI'QO 'VJ G'PARTY NAMED BELOW *****TO THE PARTY NAMED BELOW *****THE PARTY NAMED BELOW

Medical Facility/ Individual Records may be shared with

Name Individual records will be coming from or sent to (Provider, Doctor, Attorney) _____

Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Record Delivery Method (circle which applies)

FAX

MAIL

Purpose for this Disclosure (circle which applies)

Medical Care

Legal Eligibility

Determination

Client Request

Other

By INITIALING BELOW,

I GIVE MY PERMISSION TO RELEASE: All records from all dates seen by Provider/ Clinic.

Physician Reports _____ Radiology Reports _____ Exam Forms _____ Medical Log _____

Immunization Records _____ Laboratory Reports _____ Other _____

Release of the following records & information requires specific authorization: By initialing the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand they are protected by Federal & State Law (ORS433.045(3); OAR33312270(8)(a); ORS659.7100). I also understand that I may revoke this authorization at any time to the extent that information has already been released based upon this authorization.

HIV/ AIDS _____ Sexually Transmitted Disease Info. _____ Mental Health Records _____

Genetic Information _____ Drug/ Alcohol Records _____

Patient Consent

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 120 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request. I understand that by not signing this, I will still be able to receive medical care from Bridge City Family Medical Clinic.

Patient/ Guardian Signature: _____ Date: _____

The information disclosed to you by this authorization is protected by state law (ORS179.505.192.525) & Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol/ drug treatment records. Federal rules restrict the use of alcohol/drug treatment records to criminally investigate or prosecute any alcohol/drug abuse patient.

These records are being requested for continuity of care. We are requesting this as a medical courtesy and do not offer reimbursement.