Authorization to Release Medical Records

PATIENT INFORMATION:

Name (print) DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider

_____

Address

_____

Phone / Fax

_____

INFORMATION TO BE SENT TO:

Christian Family Adoptions: 6040 SE Belmont Street
Portland, Oregon 97015
P: 503-232-1211 • F: 503-232-4756

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

_____ Pregnancy related medical records

_____ All medical records

_____ Specific information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse / treatment & diagnosis _____ Sexually transmitted disease

_____ HIV/AIDS diagnosis / treatment / testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, Guardian, or Authorized Representative)

This authorization will expire 180 days from the date signed.