



# RECORD RELEASE FORM

## CASCADE PHYSICIANS, P.C.

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### Authorization for Disclosure of Protected Health Information

N.W. Portland (Good Samaritan)     Bridgetown (Emanuel)     Tualatin (Meridian Park)

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_      **Medical Record #:** \_\_\_\_\_

**Doctor Address (who has records):** \_\_\_\_\_

1. I authorize \_\_\_\_\_ to disclose my health information specific to the following date or time period: \_\_\_\_\_
2. Individual or entity authorized to receive my health information: \_\_\_\_\_  
\_\_\_\_\_
3. Purpose for which disclosure is to be made: \_\_\_\_\_  
\_\_\_\_\_
4. Please initial the information you want disclosed:
 

_____ Clinical chart notes	_____ Diagnostic Imaging Reports
_____ Hospital Records	_____ EKG
_____ Laboratory Reports	_____ Radiology Reports
_____ Pathology Reports	_____ Other _____

By initialing the space(s) below, I am specifically authorizing the release of the following:

- \_\_\_\_\_ Medical records from alcohol and/or drug abuse treatment center(s)
- \_\_\_\_\_ HIV (human immunodeficiency virus) test results
- \_\_\_\_\_ Genetic testing results

**Note:** Psychiatric (Mental Health) records require a separate release form per ORS 192.525

Restrictions requested: \_\_\_\_\_

5. I understand that if the person(s) or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Cascade Physicians, its employees, and my physician from all liability arising from this disclosure of my health information.
6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 180 days from the date signed below. I understand that I may also revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my request.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will Not affect my ability to obtain treatment, payment or my eligibility for benefits.

\_\_\_\_\_  
Signature-Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness