CASCADE PHYSICIANS, P.C.

Authorization to Release Medical Information

Patient Name _____ DOB _____ Former Name _____

Address _____ City _____ State _____ Zip _____ Contact Number _____

Information to be released FROM:

Physician / or other third part named _____

Address/Fax _____

Information to be released TO:

Physician / or other third part named _____

Address/Fax _____

Purpose of Release

☐ Changing Primary Care Physician / Clinic
☐ Referral / Consultation
☐ Self
☐ Other _____

Indicate the Type of Information to be Released Below:

☐ General Medical Records- excluding protected records

Copies of medical records will be limited to two (2) years of information including progress notes, lab and xray reports, and immunization, unless otherwise indicated below.

-OR-

☐ Specific Information Only

☐ History and Physical: specify date: _____
☐ Medications/Therapy
☐ Lab, Pathology, EKG: specify date or type:_____
☐ Other: _____
☐ Xray reports
☐ Billing
☐ Immunizations Only
☐ Operative / Hospital Report

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.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT
_____ ALCOHOLISM DIAGNOSIS /TREATMENT
_____ MENTAL HEALTH/ TREATMENT
_____ SEXUAL TRANSMITTED DISEASES
_____ AIDS/ HIV TEST RESULTS AND HIV DIAGNOSIS
_____ GENETIC TESTING

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.
You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

_____ Signature of patient or Legally Responsible person
_____ Relationship to Patient
_____ Date

19250 SW 65th Ave, Ste 110
Tualatin, OR 97062
P:(503)692-1205 / F: (503)692-1207

2222 NW Lovejoy, Ste 505
Portland, OR 97210
P:(503)226-4091 / F: (503)226-3539

24900 SE Stark, Ste 202
Gresham, OR 97030
P:(503)465-8887 / F: (503)465-8808