# AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Address _____

Social Security Number _____ Sex M F

**I AUTHORIZE MID-VALLEY PAIN CLINIC LOCATED AT:**

2925 RIVER ROAD SOUTH #250 SALEM, OR 97302 (ADDRESS) 503-371-1970 (TELEPHONE) 503-371-0192 (FAX)

TO: ☐ RELEASE INFORMATION
☐ EXCHANGE INFORMATION ☐ VERBAL OR WRITTEN
☐ RECEIVE INFORMATION
ABOUT ME TO/FROM THE FOLLOWING PERSON OR CLINIC/AGENCY:

_____ _____
Person or clinic/agency Telephone and/or FAX number

**BY INITIALING BELOW, I SPECIFICALLY AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:**

_____ Clinician office chart notes _____ Laboratory Reports _____ Medication Records

_____ Specific Records needed for continuity of care: _____

(The following records require specific authorization. Initial by responsible party indicates authorization of release of particular additional confidential information.)

_____ Mental health information _____ HIV/AIDS related records

_____ Drug Alcohol diagnosis, treatment or referral (Federal regulations require a description of how much and what kind of information is being requested.) _____

**REASON FOR THE RELEASE OF RECORDS:** ☐ Continuity of Care ☐Coordination of Care
☐Other (specify) _____

**THIS AUTHORIZATION IS LIMITED TO ONE YEAR OR AS INDICATED:** _____

I hereby request and authorize that the records listed above for the care and treatment of the above named client be provided as indicated and for the purpose specified.

I understand that this authorization may be revoked at any time, except to the extent that action has been taken in compliance with this authorization.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that the information used or disclosed may be subject to re-disclosure, except for highly confidential Information.

| Signature | Date Signed | Renewal Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |