



**AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION**

**Patient Name:**

**Date of Birth:**

**OFC Med Record #:**

This authorization must be in writing, dated and signed by the patient or a person authorized by law to give authorization

I authorize the use of the above named individual's health information as described below (include dates as needed)

- Problem list
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Most recent discharge summary
- Laboratory results from (date) to (date)
- X-ray and imaging reports from (date) to (date)
- X-ray film(s) (type) date of film(s)
- Consultation from (doctors' name)
- Entire record from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Other

This information may be disclosed to and used by the following individual or organization:

Address:

for the purpose of:

I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.

This authorization may be revoked at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain on effect for the period reasonably need to complete the request.

To revoke this authorization, please send a written statement (including your full name, address, and phone number) stating that you are revoking this authorization to:

Administrator - The Orthopedic & Fracture Clinic, 11782 SW Barnes Rd, Suite 300, Portland, Oregon 97225

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above be redisclosed and no longer protected by HIPAA Privacy regulations; however, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

A copy of this letter bearing a reproduction of the signature below is to be considered a valid authorization for release of requited information. I have read this authorization and understand it.

Signature of Patient or Legal Representative \_\_\_\_\_ Date: \_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient: \_\_\_\_\_