Oregon Specialty Infusion

A Practice of Oregon Specialty Group

MEDICAL RECORDS RELEASE / REQUEST

Authorization to release medical records per ORS 192.566

This authorization must be written, dated and signed by the patient or by a person authorized by law

I do hereby consent and authorize Oregon Specialty Infusion to release / request copies of my medical records.

Patient Name:____ DOB:________________________

Address: ____

City, State & Zip Code____ Contact Phone: ___________________

To the following Person(s) and/or to Physician's Office:

note: If addresses are not provided, it may cause a delay in your request.

Name of Dr. / Person: _________________________ Dr. Office/Facility Name: _____________________________

Address: ____

City, State & Zip Code _______________________________________

Phone #_____________________________________ **FAX #**_____________________

Duration of Records Request:

- ☐ Most Recent Visit
- ☐ Last 2 years
- ☐ Medical Records from ___________ to______________

Please **check** all the specific medical record documents that apply to your request:

- ☐ Dr. Visit Notes
- ☐ Lab Results
- ☐ Pathology Results
- ☐ Cultures
- ☐ Imaging Reports
- ☐ Nurse Notes
- ☐ Billing Statement
- ☐ Entire Medical Chart

Please place your ***initials*** besides the option below to authorize sensitive information pertaining to:
HIV/AIDS____________ *Please note: Mental Health, Genetic Testing & Drug and Alcohol related information must be obtained by your Primary Care Physician.*

This authorization may be revoked at any time. 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 in effect for the period reasonably needed to complete this request.

Signature of Patient or Legal Representative____

(refer to **consent to release information** form for verification of signature)

Relationship to patient: ______________________________ Date: ________________________