## Instructions for completing the OCFPC Record Release Form:

*(Important: Any missing or inaccurate entries may delay or void your request)*

* Photo ID may be required for patient/guardian verification.
* Be sure to write legibly and include:
	1. Birthdate
	2. Previous Name (if any)
	3. Where you would like the records to be sent (include address & fax number)
	4. Why the records are being sent (purpose of the release)
	5. Type of information that you would like released (The standard for “all records” is the last 3 years of treatment, unless specifically requested otherwise).
	6. Patient or guardian signature and date.
* If you would like the information to be faxed, please mark on the form, “Permission to Fax”. Please note, we will not fax any records that are more than 50 pages.
* Please allow up to 30 days for records to be sent as per Oregon State Law.

## Who can receive copies of medical records:

**Adult patients:** Copies of their own medical records

**Parent or Legal Guardian:** Copies of their minor child’s medical records (under 18)

**Legal Power of Attorney:** Copies of the medical records of the person named in the power of attorney (for example: Wife, husband or domestic partner, disabled adult)

# Authorization to Disclose Medical Information

**Oregon City Family Practice Clinic, P.C.** Phone: (503) 656-1484

**1420 John Adams Street, Oregon City OR 97045** Fax: (503) 650-1976

Patient Name: Date of Birth:

Parent or Guardian’s name(s) if a minor: Phone:

# Oregon City Family Practice Clinic may

OBTAIN my healthcare information from: **OR** SEND my healthcare information to

Name or organization: Address: City: State: Zip: Phone: Fax: Email:

### Information to be disclosed or received: (check all that apply):

Immunization Record(s)

Most recent chart note, date: All chart notes, last three years

Billing records, last three years or date:

EKG

Laboratory tests, last three years Radiology/Imaging, last three years

Other:

**Please Note:** All of the following Sensitive Healthcare information regarding testing, diagnosis, and treatment **will be** included unless otherwise initialed.

Please Do **Not** Send (Initial all that apply):

 HIV (AIDS virus) Drug and or Alcohol Abuse Sexually Transmitted Disease Behavioral or Mental Health

### Description of purpose and the use and or disclosure:

Transfer of Care

Legal / Attorney Review

### My rights

Second Opinion / Consult Personal Use

Insurance Claim

Other:

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed and that once health care information is disclosed, the person or organization that receives it may re-disclose it – privacy laws may no longer protect it.

1. **This authorization ends:** *(This document does not permit disclosure of health information created more than 90 or 180 days after the date it is signed. Federal Regulation, 42 CFR Part 2, requires a destination of how much and what kind of information is disclosed)*

 **90 days 180 days**

### Permission to fax information

I consent to have my medical records faxed. All faxed documents contain a statement of confidentiality, however, I understand that confidentiality on the receiving end cannot be guaranteed. **Yes No**

 This information is limited to the following treatment:

 This authorization is limited to the following time period:

 This authorization is limited to worker’s compensation claim for injuries sustained on this date:

I authorize the transfer of my healthcare information **to or from** the **above address**. I understand that no charge will be made for transfer of information to another health care facility or myself. However, if health care information is transferred to another person or third party such as an attorney or insurance company, the charge will be $30.00 for the first 10 pages, plus $0.50 per page up to 50 pages, and $0.25 per page after 50 pages. Payment is due before records are rendered.

**Patient’s Signature** (if 16 years or older) **Date**

**Parent or Legal Guardian Signature** (if patient is under 16 years of age) **Date**