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## RELEASE OF INFORMATION

Purpose: This form is an authorization to release protected health information.

### SECTION A: Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### SECTION B:

#### Protected Health Information to be Released

##### Date of Service OR Description of Service

- Emergency Room \_\_\_\_\_
- Lab Reports \_\_\_\_\_
- Imaging CD/ Reports \_\_\_\_\_
- EKG/ EEG \_\_\_\_\_
- History & Physical \_\_\_\_\_
- Inpatient Progress Notes \_\_\_\_\_
- Operative Report \_\_\_\_\_
- Discharge Summary \_\_\_\_\_
- Clinic Chart Notes \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- Other\* \_\_\_\_\_

##### (\*specify) \_\_\_\_\_

### SECTION C:

#### Send Records To:    Request Records From:

Individual/Facility / Agency \_\_\_\_\_

Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Tel Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Email Address \_\_\_\_\_

### SECTION D: I specifically release the following:

- HIV/AIDS/STD's \_\_\_\_\_ (Initials)
- Drug/Alcohol Diagnosis and Treatment \_\_\_\_\_ (Initials)
- Mental Health Diagnosis and Treatment \_\_\_\_\_ (Initials)
- Genetic Info \_\_\_\_\_ (Initials)

### PATIENT'S SIGNATURE.

I have had the full opportunity to read and consider the contents of this authorization. I understand that by signing this form I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Patient Signature/Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name: \_\_\_\_\_

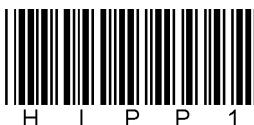
Relationship to Patient: \_\_\_\_\_

### SECTION E: Purpose of this Authorization:

- Continuing Care
- Insurance
- Legal
- Other: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

PATIENT STICKER



**Include this authorization in the individual's medical records**

**FOR HOSPITAL USE**

Date prepared: \_\_\_\_\_ Initial: \_\_\_\_\_

Date of release: \_\_\_\_\_  Pt. Pick-Up  Mailed  Faxed  Electronic

Verification of ID:  Photo ID  Person is known to me  Government Credentials

Verified by: *(CMH Staff Signature)*: \_\_\_\_\_

Medical Record Number \_\_\_\_\_

PATIENT STICKER