Medical Records Release Authorization

This *authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.*

Patient: _____ Social Security #: _____-_____-_____ DOB: _____/_____/_____

Circle the options that applies:
Please **send / obtain** my medical information **to / from**:

_____
Name of Physician

_____
Name of Clinic/Hospital (if applicable)

_____
Street Address

_____
City, State, Zip Code

_____
Phone/Fax

Circle the options that applies:
Please **send** / **obtain my** information **to / from**:

8 Hearts Health & Wellness
5331 SW Macadam Ave, Suite 380
Portland, OR 97239
Phone: 503-894-9118
Fax: 503-894-7398

By ***checking*** the spaces below, I authorize 8 Hearts Health & Wellness or the above physician/clinic/hospital to release written records pertaining to the following information ***going back one year***. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

____ Medical records needed for continuity of care
____ Diagnostic imaging reports
____ Laboratory reports
____ Pathology reports

____ Other: _____

_____ _____
Date Patient Signature

_____
Signature of Parent/Guardian if Applicable

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By **signing** the spaces below, I specifically authorize the release and use of the confidential information above by 8 Hearts Health & Wellness and the named physician/clinic/hospital. I also authorize the physician/clinic/hospital to provide the information via telephone consultation:

_____
Patient Signature

HIV/AIDS test results and related information, including high risk behavior documentation. **This information may not be further disclosed without The specific written authorization of the tested individual**

_____
Patient Signature

Drug/Alcohol diagnosis, treatment, or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind Of information is to be disclosed. Please provide a description of this information:

_____
Patient Signature

Mental Health treatment information

Office use only: Date sent: _____ Initials: _____