slocum

center for
orthopedics &
sports medicine

Records Release from Slocum

I authorize a copy of the medical information for _____ DOB_____
(Full Name)

To be released to: From:

Name: _____ **SLOCUM CENTER ORTHOPEDICS & SPORTS MEDICINE**

Address: _____ 55 Coburg Road Eugene, OR 97401
(541) 485-8111

City, St., Zip _____ (541) 342-6379 Fax

Phone (_____)_____

The information will be used on my behalf for the following purpose(s):_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

( ) Medical records needed for continuity of care (specify body part) _____

( ) X-rays ( ) X-ray Films ( ) X-ray Reports

( ) MRI, CT, bone Scan, Ultrasound reports

( ) Physical therapy reports

( ) Other (please specify)_____

( ) Please send the entire medical record (all information) to the above recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

SEPARATE, SIGNED AUTHORIZATION FORM REQUIRED FOR THE FOLLOWING:

HIV/AIDS related records **Mental health information**

Genetic testing information **Drug/alcohol diagnosis, treatment or referral information**

( ) This authorization is limited to the following treatment:

_____

( ) This authorization is limited to the following time period:

_____

( ) This authorization is limited to workers' compensation claim for injuries of:

_____

I understand that, information disclosed as directed by this authorization is subject to re-disclosure by the recipient and no longer protected under federal law.

I understand I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Slocum Center nor will it affect my eligibility for benefits.

I understand my information may be mailed or faxed depending on the urgency of the request.

I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 180 days from the date of signing.

Slocum Center, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Person making the request_____Relationship to Patient_____

Signed_____ (Date)_____
(Signature of patient or person authorized by law and relationship to patient)

Mailed_____ Faxed_____ Patient Pick Up_____

Slocum Staff Signature _____ Date _____