slocum

orthopedics, p.c.

Authorization to Release Medical Records

I authorize a copy of the medical information for

_____ DOB:_____

Full Name

From:		**To be released to:**
Name:	_____	Slocum Center for Orthopedics & Sports Medicine
Address:	_____	55 Coburg Rd.
City, State, Zip:	_____	Eugene, OR 97401
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 (specific body part) _____

( ) X-rays

( ) 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	Genetic testing information
Mental health information	Drug/alcohol diagnosis, treatment or referral information

☐ This authorization is limited to the following statement:

_____

☐ This authorization is limited to the following time period:

_____

☐ This authorization is limited to workers compensation claim for injuries of:

_____

I understand that the 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.

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

I understand that 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, the authorization will expire 180 days from the date of signing.

_____ _____

Signature of patient or person authorized by law and relationship to patient Date