Applegate Medical Associates
689 E 19th Ave
Eugene, OR 97401
Phone: 541-868-1876 Fax: 541-868-0932

Please return a copy of this patient authorization with the attached records.

Patient Name: _____ Other Names Used: _____

Date of Birth: _____ Phone Number: _____

1. Purpose of Release Request:

☐Transfer of Care ☐Moving/Relocation outside area ☐Specialist ☐Self-Use
☐Legal Reasons ☐Doctor Consultation/Referral ☐Other: _____

2. Type of General Medical Information to be released:

☐ **ALL** Physician notes and records limited to two years of information and excludes other protected records
☐ Lab test results. Please specify tests and their date_____
☐ Imaging reports (MRI, X-ray, CT, etc....) Please specify their dates_____
☐ Electrocardiogram (ECG/EKG) Reports
☐ Visit/Encounter Notes
☐ Immunization Records
☐ Diagnosis List
☐ Vaccine and Medication Record
☐ Problem List
☐ Operative Report
☐ Health Information Summary
☐ List of Allergies
☐ Billing Records
☐ History and Physical Exam
☐ Medication List
☐ Other Records or Test Results. Please Specify:_____

This request is being made:
☐ At the patient request ☐ At the request of the recipient
By **INITIALING** in the spaces below, I specifically authorize the disclosure of the following information that may have additional state and federal protections:
_____ Mental Health Information
_____ Drug/Alcohol Conditions
_____ HIV/AIDS Information
_____ Genetic Information
Release of the above information is limited to:
_____ Time period
_____ Treatment dates

3. I authorized the information designated above to be released from:

Name of Facility: _____
Street Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

4. I authorize the information designated above to be released to:

Applegate Medical Associates
689 E 19th Ave
Eugene, OR 97401
541-868-1876
541-868-0932

5. Expiration of Authorization of Release

This authorization is valid for 90 days from the date of this authorization or until ____/____/_____, unless revoked by the patient in writing at an earlier time. I understand that if I am requesting information from Applegate Medical Associates, I can revoke this authorization in writing and I will need to send a letter to the organization that gave out the information, and who is shown above. The exception is when the action has already occurred as instructed in this authorization. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

6. Disclosure and Authorization Signature

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or in order for payment for healthcare to be made. However, if the healthcare services are going to be provided solely for providing health information to someone else, then my signature on this authorization is necessary to make this disclosure. I will not receive these health services if I refuse to sign. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Applegate Medical Associates. I understand that if the organization that gets this information is not a healthcare provider by Federal Privacy Laws, the information listed above could be given out by them, and will not be protected by those regulations. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, genetic information or referral information.

_____
Signature of Patient or Authorized Representative Today's Date

_____
Printed Name of Patient or Authorized Representative Legal Representative's Relationship to Patient