Patient: ____ DOB: ___________ MRN: ___________

4212 NE Broadway ● Portland, Oregon 97213 ● (503)249-8787 ● Fax: (503)284-5168 ● www.broadwaymedicalclinic.com

MEDICAL RECORDS RELEASE FORM

I authorize Broadway Medical Clinic to use and disclose a copy of my specific health information consisting of:

☐ Last 2 years ☐ from: ___/___/___ to: ___/___/___ ☐ other (please specify) ____________________

Reason for release (check one): ☐ Transfer of care ☐ Continuity of care ☐ Coordination of care

To: ____

(Name of physician / entity / location / address / phone number / fax number)

-OR-

From: ____

(Name of physician / entity / location / address / phone number / fax number)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Mental health information
_____ Drug/alcohol diagnosis, treatment, or referral information _____ Genetic testing

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, and treatment or referral information. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Broadway Medical Clinic and state that you are revoking the authorization.

I have read this authorization and understand its purpose.

Unless revoked, this authorization expires: _______________ (insert date or event) or 180 days from the date signed below.

Signed By: ____________________________________ **Name (Print):**____________________________ **Date:** _________

Relation to Patient (check one): ☐Self ☐Parent/Legal Guardian ☐Authorized Representative