LOWER UMPQUA HOSPITAL
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2171 ~ Fax: (541) 271-6322 (Medical Records)
or (541) 271- 6363 (Emergency Room) as requested.

# AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ to release a copy of the medical information for _____(name of patient), (date of birth) _____ to _____ (name and address of recipient).

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: PLEASE INITIAL –

_____ All hospital records (including nursing records and progress notes)

_____ Transcribed reports

_____ Most recent 2 year history

_____ Physical Therapy records

_____ Laboratory reports

_____ Operative reports and/or Path reports

_____ Dental records

_____ Clinical office chart notes

_____ Medical records for continuity of care

_____ Emergency care records

_____ Billing statements

_____ Radiology reports

_____ Other: _____

This authorization is limited to:

Following treatment: _____
Following time period: _____
Workers compensation claim for injuries of _____ (date)

* MUST BE INITIALED TO BE INCLUDED IN OTHER DOCUMENTS:

_____ HIV/AIDS RELATED RECORDS
_____ GENETIC TESTING INFORMATION
_____ MENTAL HEALTH RECORDS
_____ DRUG/ALCOHOL RECORDS

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

_____ _____
(date) (Signature of patient) or

_____ _____
(date) (Signature of guardian/person authorized by law)

_____ _____
(date) Witness – staff at facility

revised 1/09