LOWER UMPQUA HOSPITAL
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2171 ~ Fax: (541) 271-6322 (Medical Records) **MRN:**
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 ***(facility)*** ________________________________ to release a copy of the medical information for ***(name of patient)*** ________________________________, ***(date of birth)*** ____________________________ to ***(name and address of recipient)*** ____.

ID CHECKED:_______ BY:________________________

The information will be used on my behalf for the following purpose: [ ] Continuity of Care, [ ] Personal Records, [ ] Insurance (Aflac,etc), [ ] Other ______________________

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 notes/progress notes)
_____ Most recent 2 year history (dictations, labs, x-rays)
_____ Physical Therapy records
_____ Laboratory reports
_____ Operative reports and/or Path reports
_____ Progress Notes/Medication list
_____ Medical records for continuity of care (dictations, labs, x-rays)
_____ Emergency care records
_____ Billing statements
_____ Radiology reports
_____ Other: ____

This authorization is limited to:

Following date's/treatment:____

____

Workers compensation claim for injuries of ____________________________ (*date*)

MUST BE INITIALED TO BE INCLUDED:

______ **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. *A new authorization form must be completed* ***each*** *time records are requested.*

__________ (date) ________________________ ***(Signature of patient)*** ***or*** ________________________ ***(guardian/person authorized by law)***

__________ (date) ________________________ ***Witness – staff at facility***

revised 10/13