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 ***(facility)*** _____ 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: [ ] Continuity of Care, [ ] Personal Records, [ ] Insurance , [ ] Other _____
(Aflac,etc)

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

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

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

_____ _____
(date) ***Witness – staff at facility***

revised 5/12