OHSUHealth
Hillsboro Medical Center

Med Rec #: _____

Employee name: _____

Date received: _____/ _____/ _____

Release of Information of Medical Records

Medical Records Department (ROI) ▪ 335 SE 8th Ave. Hillsboro, OR 97123 ▪ **Tel:** (503)681-1195 ▪ **Fax:** (503)681-1969 ▪ **Email:** ROI@tuality.org

Authorization to obtain and disclose medical information. Please complete the following information.

Patient name: _____ Date of Birth: _____/ _____/_____

Address: _____ City/ State/ Zip: _____

Tel: _____ Email/Fax: _____

Release records to (check all that applies):

❒ **Patient -** same information listed above ❒ **BOTH**

❒ **Other -** please fill in **THEIR** information below [individual or healthcare facility]:

_____
Name

_____
Address City / State / Zip

_____
Tel Email / Fax

Information you want to release / obtain

Specific info/dates: _____

_____

❒ **Pertinent records -** last two (2) years, default

❒ **Lab report(s)**

❒ **Radiology report(s) / films**

❒ **Emergency / Urgent Care records**

❒ **Immunizations**

❒ **Other** (specify):_____

_____

_____

Obtaining your specially protected records

If my information contains any of the types of records listed below, additional laws relating to the use and disclosure of my information may apply. **By initialing the applicable below**, I understand and agree that this information will be disclosed to the personnel listed above.

____ **HIV / AIDS testing**

____ **Mental Health records**

____ **Genetic testing information**

____ **Drug / alcohol diagnosis, treatment or referral info.**

Preferred delivery method: ❒ Mail ❒ Email ❒ Fax ❒ MyChart ❒ Pick-up

Reason for request (check one):

❒ Continuing care ❒ Personal ❒ Legal ❒ Insurance ❒ Other: _____

Restrictions

I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/ or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

_____

Patient/ Legal guardian signature **Date** **Guarantor, POA, or other legal representative**

Expiration date: This authorization will expire 12 months from date of signing unless revoked or otherwise specified below:

Alternative expiration date or event: _____