

# Authorization for Release of Records



**COLUMBIA GORGE**  
FAMILY MEDICINE

**Birthdate:** \_\_\_\_\_  
(mm/dd/yyyy)

1750 12th Street  
Hood River, OR 97031

Phone: 541-386-5070  
Fax: 541-386-7190  
Web: www.cgfm.com

**Patient Name:** \_\_\_\_\_  
(last name, first name, middle initial)

**Previous Name:** \_\_\_\_\_

For the purposes of:  Transfer of care     Continuing care     Personal     Legal  
 Appointment with \_\_\_\_\_ on \_\_\_\_\_

**I hereby authorize Columbia Gorge Family Medicine to request or release my medical records from or to the organization or individual listed below within the following restrictions:**

To receive records from: \_\_\_\_\_ Name/Specialty  
 To send records to: \_\_\_\_\_ Address  
 To provide records verbally with: \_\_\_\_\_  
City, State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_

## Disclosure Restrictions:

### Information to be released:

\_\_\_\_ All Records for 2 years    \_\_\_\_ Medical Summary  
\_\_\_\_ Last Physical Exam/WCC/Diabetic Exam/Sports physical (circle one)  
\_\_\_\_ Immunizations    \_\_\_\_ Med List    \_\_\_\_ EKGs    \_\_\_\_ PAP/HPV  
\_\_\_\_ Labs: \_\_\_\_\_  
\_\_\_\_ Radiology Reports: \_\_\_\_\_  
\_\_\_\_ Colonoscopy/path/recommendation    \_\_\_\_ Hospital Admit/Discharge/ER  
\_\_\_\_ Other \_\_\_\_\_

Oregon law allows you to restrict disclosure of the following types of health information. Check all that apply.

- Mental health records
- Referral for substance abuse:
- Related to HIV/AIDS or STDs

This authorization is valid for 180 days and can be revoked at any time by contacting CGFM's medical records department.

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of patient

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

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