Authorization for Release of Records

COLUMBIA GORGE
FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

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

Birthdate: _____
(mm/dd/yyyy)

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