PERMISSION TO RELEASE
MEDICAL RECORDS & MEDICAL INFORMATION

I understand that The Aurora Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Home: _____ SS#:_____

I authorize information to be released FROM:

Name of Facility/Doctor: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ Fax: _____

I authorize information to be released TO:
The Aurora Clinic
1847 East Burnside Suite B
Portland, OR 97214
This information will be used for the following purposes:
X Patient Care _____ Legal Review (Type of injury and Date)
X Medical Review

INITIAL on all lines below for type of information to be released:
_____ ALL Records (Limited to 2 years) pertaining to my diagnosis of: _____
_____ Physician Notes and Records (Limited to 2 years - EXCLUDES protected records unless initialed below)
HIV/Aids Information _____ Drug/ Alcohol Information _____ Psychiatric Data _____

Expiration: Unless revoked in writing, this authorization expires 180 days from the date of signature.
Faxing Limits: Please limit faxed records to 20 pages. All other records may be submitted by mail in hard copy or digitally as a PFD on a CD. Please DO NOT send X-Rays, MRIs or X-Ray film. The Aurora Clinic does not pay for medical records.
Disclosure Statement: I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of the "Sender" or you. This information may not be protected by Federal privacy regulation
Revocation: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or other have acted in reliance upon this Authorization.
Disclaimer: Your general medical information may contain references to your mental state, drug and alcohol condtions, or HIV status or sexually transmitted diseases. Release of this information in your general medical record requires additional authorized signatures.
Fax Authorization: I specifically give authorization to FAX my medical information. I understand risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

_____

Patient's Signature (OR Legally responsible person- state relationship to patient)

_____

Date