Willamette Valley Endocrinology

Encouraging and Healing one patient at a time

700 BELLEVUE S.E., SUITE 240
SALEM, OREGON 97301

PHYSICIAN'S AND P.A.'s of
ENDOCRINOLOGY AND METABOLISM

TELEPHONE (503) 399-8105
FAX (503) 581-5351

Medical Records Release

Purpose of Request

□ At the request of the patient □ Billing or claims payment □ At the request of the provider □ Other___

Patient Information

First Name_____Last Name_____Date of Birth___/____/_____
Telephone_____Address_____

Party Receiving Information:

Facility Name_____
Provider Name_____
Address_____
Telephone_____Fax_____

Party Releasing Information:

Facility Name_____
Provider Name_____
Address_____
Telephone_____Fax_____

Type of information to be released *(Dates: From_____To_____)*

□ Emergency room report □ Hospital Records □ Nuclear Medicine Reports □ Chart note
□ Imaging reports □ Lab results □ Discharge Summary □ Consultation
□ Other_____ □ All records

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, generic testing, and/or other sensitive information, I agree to release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. *Initial: ____Yes or _____No*

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurances Portability and Accountability Act (HIPAA) of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Willamette Valley Endocrinology may not condition my treatment on whether I sign this authorization for unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Willamette Valley Endocrinology to use and disclose the protected health information specified above.

Patient Signature_____Date_____
Relations if not the patient_____Date_____

Unless revoked in writing, this medical release form will expire in 180 days.