

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

SUNSET MEDICAL PRACTICE GROUP, PC

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Phone: 503-626-0939 • FAX 503-626-6161

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Current Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Reason \_\_\_\_\_ Transfer Primary Care \_\_\_\_\_ Specialist \_\_\_\_\_ Other: \_\_\_\_\_

I authorize information to be released from:

My records are to be sent to:

Facility/Physician \_\_\_\_\_

Facility/Physician \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone/Fax \_\_\_\_\_

Phone/Fax \_\_\_\_\_

This authorization shall begin immediately and remain in effect for not more than 180 days from this date unless another date is specified.

By **initialing** the spaces below, I authorize the use and disclosure of the following medical information and/or medical records.

\_\_\_\_\_ Most recent 3 year history or \_\_\_\_\_

\_\_\_\_\_ Physical Therapy Records

\_\_\_\_\_ Hospital Records

\_\_\_\_\_ Office Chart Notes

\_\_\_\_\_ Laboratory Records

\_\_\_\_\_ Immunizations

\_\_\_\_\_ Pathology Reports

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Diagnostic Imaging

**Protected or Sensitive Information**

Specific authorization is required to release the following protected information. Initial below in the specified box if you agree to release this information.

I recognize that the information disclosed may contain sensitive information that is protected under federal and state laws. I consent to the disclosure of this information from my medical record.

\_\_\_\_\_ Drug/Alcohol

\_\_\_\_\_ Mental Health

\_\_\_\_\_ HIV/AIDS/STD

\_\_\_\_\_ Genetic

Permission to Fax protected health information from my medical record.

Yes \_\_\_\_\_ No \_\_\_\_\_ My initials give specific consent to the faxing of my information from my medical record. I understand that a confidentiality statement is included on the fax cover sheet, but it cannot guarantee the confidential transmitting of my protected health information.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date