

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

SUNSET FAMILY PRACTICE GROUP, PC

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

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

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

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 2 year history

\_\_\_\_\_ 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 DRUG/ALCOHOL related information that is protected under federal and state laws. I consent to the disclosure of this information from my medical record.

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

\_\_\_\_\_ I recognize that the information disclosed may contain HIV/AIDS related information that is protected under federal and state laws. I consent to the disclosure of this information from my medical record.

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