AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Please Fax Records To: 503-874-0575

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I, (Patient Name) _____, do authorize the

doctor or facility listed below to release a copy of medical information to Falls Canyon Surgical Associates, 450 Welch

Street, Silverton, OR 97381. Phone: 503-874-0574

Doctor or Facility to Release Records: _____

Doctor or Facility Address: _____

Phone: _____ Fax: _____

The information will be used on my behalf for the following purpose(s): □ Continuity of Care □ Other

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____	All hospital records	____	Clinician office chart notes
____	Diagnostic imaging reports	____	Procedure Reports
____	Laboratory reports	____	Pathology reports
____	Other: _____		
____	Please send entire medical record (all information) to the above names recipient.		

INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:

____	HIV/AIDS related records	____	Mental Health information
____	Genetic testing information	____	Drug/Alcohol diagnosis, treatment or referral information

I understand that if the person(s) or entity (ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Falls Canyon Surgical Associates, its employees, and providers from all liability arising from this disclosure of my health information.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. A copy of this authorization will have the same effect as an original.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Print Patient Name: _____ DOB of Patient: _____

Signature: _____ Date: _____