



Medical Record Release

I hereby authorize:

Name of disclosing party

Address

City

State

Zip

To disclose to:

Name of recipient

Address

City

State

Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used)

SSN

Date of Birth

Address

Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

☐ Medical information _____ (initials)

☐ Psychiatric information

Signature

Date

☐ Drug/Alcohol Information

Signature

Date

☐ Results of HIV Test

Signature

Date

☐ Genetic Records

Signature

Date

☐ Other Health Information _____ (initials and specify below)

☐ Specify the records to be disclosed: _____

This authorization ☐ **does** / ☐ **does not** discontinue my care through AllCare Medical Group.

The recipient may use the health information authorized on this form for the following purposes:

Signature

Date

If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)

Douglas
(541) 476-7000

Glendale
(541) 832-5400

Illinois Valley
(541) 450-3625

Mountainview
(541) 471-2701

Rogue
(541) 244-2197

Shady Cove
(541) 878-2022

WellSpring
(541) 474-6053