Authorization to Release Medical Information:

Patient Name: _____
First Middle Last
Street Address: _____

City: _____ State: _____ Zip Code_____

Head of Household: _____

Patient Birthdate: _____ Soc. Sec. # _____ Tel: _____

Please **SEND** information **TO** the following:

Full Name of Physician: _____

Name of Clinic/Hospital: _____

Street Address: _____

City: _____State: _____ Zip: _____

Tel: _____ Fax: _____

Please **OBTAIN** my medical information **FROM**:

Dr. Cheryl B. Hickethier, MD, MPH

Physician to receive information

PO Box 3039

Clackamas, OR 97015

Fax: 503-656-5658

Purpose for which disclosure is to be made: _____New PCP_____

I authorize the above named facility to release the following information:

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist.

_____ Please send the entire medical record (all information) to the above named recipient doctor.
The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

_____ Most recent five-year history
_____ Medical records needed for continuity of care
_____ Laboratory results
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinical office charts notes
_____ Emergency/Urgent care
_____ Other _____

_____*HIV/AIDS-related records _____* Mental health information _____* Genetic testing information
***Must be initialed to be included in other documents.**

____ ** Drug/alcohol diagnostics, treatment or referral information

**** Federal Regulations 42 CFR Part 2 requires a description of how much & what kind of information will be disclosed.**

Consent may be revoked at any time. The only exception is when action has already occurred as instructed in the consent. Unless revoked earlier (in writing), this consent will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
I understand that I may refuse to sign this authorization and that refusal to sign will not affect my ability to obtain treatment, payment or eligibility. However, Dr. Hickethier does remind her clients, that failure to provide important medical information (diagnostic tests, specialist consults, hospitalization), can affect the outcome of the treatment.
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 redisclosed and is no longer protected by those regulations. Therefore, I release Dr. Cheryl B. Hickethier, MD, MPH, and her staff from all liability arising from this disclosure of my health information.

Patient/Parent or Legal Guardian _____ Date consent given _____

Witness _____ Physician's approval _____