

RETURN THIS FORM TO THE FACILITY WHO WILL
BE PROVIDING COPIES OF YOUR RECORDS

Authorization to Release Medical Information TO MMCS Clinic

USE THIS FORM TO HAVE RECORDS SENT TO YOUR PROVIDER AT MMCS CLINIC

Patient Name _____ DOB _____ Former
Name _____

Current Address _____ City _____ State
Zip _____

Daytime Phone # _____ Evening Phone # _____ SS#

I authorize information released from:

Physician/or other third party named

Address

City, State, Zip

Please send my records/films to (check one):

Main Office: 4911 NE Sandy Blvd Portland, Or 97213

INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW

General Medical Records –excluding protected records.

Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and diagnoses.

Other _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law.

BY INITIALING I authorize the release of the following protected or sensitive information.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT _____ SEXUALLY TRANSMITTED
DISEASES

_____ ALCOHOLISM DIAGNOSIS/TREATMENT _____ AIDS/HIV TEST RESULTS
INCLUDING

RELATED HIGH RISK BEHAVIOR

_____ MENTAL HEALTH/TREATMENT _____ GENETIC TESTING

•By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information. •You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing. You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

Signature of patient or legally responsible person relationship to patient date