

THE OFFICES OF
David Dodge, MD ▼ Thomas Orvald, MD ▼ Sandra Camacho, MD ▼ Rabia Ahmed, MD
Eric Eisenbud, MD ▼ Paul Ironside, MD ▼ Leo Capobianco, MD
Main Office: 105 SE 18th Avenue ▼ Portland, OR 97214
503.281.5100 Phone ▼ **503.235.0120 Fax** ▼ 800.723.0188 Toll-Free

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

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

Phone: _____

I authorize: _____ Fax: _____

(Doctor or clinic name—MUST BE MD or DO)

to release medical information for:

Patient Name: _____ **Date of Birth:** _____

Patient Telephone Number: () _____
Area Code

to the offices of the doctors listed above. Information will be used for continuity of patient care relating to the following medical condition(s): _____

By **INITIALING NEXT TO THE Xs BELOW**, I specifically authorize the release of the following:

**INITIAL
HERE**

- _____ Clinician office chart notes (**MOST RECENT THREE VISITS ONLY**)
- _____ Diagnostic imaging reports (**PAST THREE YEARS ONLY**)
- _____ *HIV/AIDS-related records (**PAST THREE YEARS ONLY**)
- _____ *Drug and alcohol-related records (**PAST THREE YEARS ONLY**)

*Must be initialed to be included with other documentation

**PLEASE
SEND THIS
FORM
WITH
MEDICAL
RECORDS**

**INITIAL
HERE**

PERMISSION TO FAX INFORMATION: **YES** _____

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. This authorization may be revoked at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonable to complete the request. I understand that your office will not condition treatment on signing this document, or failure to do so. I further understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

Date: _____ Signature: _____

PLEASE DON'T FAX MORE THAN 25 PAGES WITHOUT CALLING FIRST!