

**WEST LINN FAMILY HEALTH CENTER, P.C.**

18380 WILLAMETTE DRIVE, SUITE 202 - WEST LINN, OREGON 97068-1718 - PHONE (503) 635-8384 - FAX (503) 636-6475

JOYCE S. ENDO, MD • DAVID B. FARLEY, MD • BREANNA L. PERCELL, MD • RYAN G. SCOTT, MD

LINDA CIOFFI, NP • LIBERTY FORT, P A • CAROLYN GARNETT, PA • ANDREW GERRY, NP • CHERIE MARTCHENKE, NP

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**RELEASE FROM:** (check appropriate box or fill in info)

Physician name: \_\_\_\_\_

**West Linn Family Health Center**  
18380 Willamette Drive Ste. 202  
West Linn, OR 97068  
Phone: 503-635-8384  
Fax: 503-636-6475

Facility Name \_\_\_\_\_  
Address \_\_\_\_\_  
City,State,Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

**RELEASE TO:** (check appropriate box or fill in info)

Name: \_\_\_\_\_  
Name of person receiving information

\_\_\_\_\_ Title (patient, spouse, physician, attorney, etc.)

**West Linn Family Health Center**  
18380 Willamette Drive Ste. 202  
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Phone: 503-635-8384  
Fax: 503-636-6475

Facility Name \_\_\_\_\_  
Address \_\_\_\_\_  
City,State,Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

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Patient Name Date of Birth  
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Patient Name Date of Birth

Purpose for Release:  transfer of care  
 other: \_\_\_\_\_

Information to be Released:  all medical records  
 other: \_\_\_\_\_

*I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.*

By: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Guardian Signature

Guardian Relationship \_\_\_\_\_

Date request completed \_\_\_\_\_ By \_\_\_\_\_