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

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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
West Linn, OR 97068
Phone: 503-635-8384
Fax: 503-636-6475

☐ Facility Name_____
Address_____
City,State,Zip_____
Phone_____
Fax_____

_____ _____
Patient Name Date of Birth

_____ _____
Patient Name Date of Birth

_____ _____
Patient Name Date of Birth

_____ _____
Patient Name Date of Birth

Purpose for Release: ☐ transfer of care ☐ other: _____

Information to be Released: ☐ all medical records ☐ other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed **only if I place my *initials* in the applicable space** next to the type of information.

_____ Genetic testing information _____ Mental health information
_____HIV/AIDS information _____Drug/Alcohol Treatment

You may revoke this authorization in writing at any time except to the extent that our office has already acted on this authorization. To do so, submit a written request stating that you are revoking this authorization to WLFHC, 18380 Willamette Dr. Ste 202, West Linn, OR 97068.

Unless revoked, this authorization expires 365 days from date of signing.

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:_____ Guardian Relationship: _____
Patient or Guardian Signature

Updated 05/25/2017