HILLSBORO CLINIC
Excellence in Primary Care

356 SE 9th Ave
Hillsboro, OR 97213
www.HillsboroClinic.com
503.681.4366 (phone)
503.681.4374 (fax)

DR. MARC E. LEWIS DR. MEENAKSHI AGGARWAL ANNE DUNNE, FNP MELINDA SANFILIPPO, FNP

PATIENT: _____ DOB: _____

Authorization to Release Medical Information

I hereby authorize:

Hillsboro Clinic
356 SE 9th Ave
Hillsboro, OR 97123

To provide medical information to:

_____
(Name of Facility)

_____
(Address)

_____
(City, State, Zip Code)

Data Requested:

_____Entire Record _____Labs, Imaging Reports
_____History & Physical _____Other
_____Operative/Pathology Reports

For the purpose of: _____

By checking and signing, I specifically authorize the release of the following confidential information:

_____ HIV Test results & related information or referral information
_____ Drug/alcohol diagnosis, treatment or referral information
_____ Mental health treatment information
_____ Genetic information

_____ _____
(Patient Signature) (Date) (Parent/Legal Guardian) (Date)

Restrictions: I authorize disclosure of my medical records for the purpose stated above. I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken on this authorization.

_____ _____
(Patient Signature) (Date) (Parent/Legal Guardian) (Date)

Permission to fax and/or send electronically: ___Yes ___No

All faxed materials will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot always be assured.