HILLSBORO CLINIC
Excellence in Primary Care

356 SE 9th Ave
Hillsboro, OR 97123
www.HillsboroClinic.com
503.681.4366 (phone)
503.681.4374 (fax)

Dr. Marc Lewis Dr. Meenakshi Aggarwal Anne Dunne, DNP Caitlin Hale, PA-C Melinda Sanfilippo, FNP

PATIENT: _____ DOB: _____

Authorization to Release Medical Information

I hereby authorize:

_____
(Name of Facility)

_____
(Address)

_____
(City, State, Zip Code)

To provide medical information to:

HILLSBORO CLINIC
(Name of Facility)

356 SE 9TH AVE
(Address)

HILLSBORO OR 97123
(City, State, Zip Code)

Data Requested:

_____ Entire Record
_____ History & Physical
_____ Operative/Pathology Reports
_____ Labs, Imaging Reports
_____ Other

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.