MMCS Clinic Medical Records Release Form

PLEASE RETURN THIS FORM WITH PATIENT'S MEDICAL RECORDS

This authorization for use or disclosure of my health information is required by state and federal law.

Patient's Name:_____DOB_____
Last First MI

_____
Address City State Zip

Daytime Telephone Number: _____

Evening Telephone Number: _____

I Authorize the following Person or Organization to Release My Medical Records:
Name of Hospital or Physician:
FAX:
Release My Health Information To:
MMCS Clinic 4911 NE Sandy Blvd., Portland, OR 97213
Phone: 503.384.9333 FAX: 503.281.9333

This Authorization applies to the following Information: All Records [X]

The Recipient may use the information for the following: Continued Care/Consultation

A specific authorization is required to release information regarding the following:

	YES	**INITIALS**
HIV Information	[X]	_____
Drug/Alcohol Information	[X]	_____
Mental Health Information	[X]	_____

I may revoke this authorization at any time in writing. The revocation must be signed by me or on my behalf and sent to the address on this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid. Unless otherwise revoked, this authorization will expire in one year. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period.

Additional time period: NONE ☐ Specify: _____

Include future records generated during the additional time period ☐

Patient Signature_____Date:_____

Patient/Personal Representative Signature_____

Relationship to Patient_____

ATTENTION: Failure to endorse this medical record release form will result in denial of request. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. I understand that if I am requesting the records for myself or my attorney there will be a fee. There is not a fee for having records sent to another medical provider.