

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525**

***This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.***

**FROM:**

\_\_\_\_\_  
(Name of hospital/ **prior** health care provider)

\_\_\_\_\_  
(Address of **prior** provider)

**To disclose a copy of the medical information for:**

\_\_\_\_\_  
(Name of patient)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
Social Security Number

**TO: Family Practice Group**  
229 Stewart Avenue  
Medford, OR 97501-3663  
Phone: 541-779-5531  
Fax: 541-618-6452

Ashley Peterson, MD  
 Caryn Belafsky, MD  
 Dea Collins, MSA, FNP  
 Denise Ledbetter, PA-C  
 Eric Ring, MD

Jill Celestsky, FNP  
 Julie Lucero, PA-C  
 Rex Strickler, PA-C  
 Tom Margulies, MD

**Purpose of Disclosure (circle one):**

Permanent Transfer

Consultation

Other

**Information to be Used or Disclosed**

**By initialing the spaces below**, I specifically authorize the disclosure of the following medical records, if such records exist:

\_\_\_ Hospital records (including nursing records and progress notes)

\_\_\_ **Most recent five years records**

\_\_\_ Transcribed hospital records

\_\_\_ Medical records needed for continuity of care

\_\_\_ Laboratory reports

\_\_\_ Billing statements

\_\_\_ Pathology reports

\_\_\_ Diagnostic imaging reports

\_\_\_ Clinician office chart notes

\_\_\_ Physical therapy records

\_\_\_ Emergency and urgent care reports

\_\_\_ Other

\_\_\_ **OR** Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

**PROTECTED OR SENSITIVE INFORMATION: I UNDERSTAND THAT CERTAIN INFORMATION CAN NOT BE RELEASED WITHOUT SPECIFIC AUTHORIZATION AS REQUIRED BY FEDERAL/STATE.**

**BY INITIALING, I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED OR SENSITIVE INFORMATION:**

\_\_\_ HIV/AIDS/STD related records

\_\_\_ Genetic testing information

\_\_\_ Mental health information

\_\_\_ Drug/alcohol diagnosis, treatment or referral information

**Expiration Date of Authorization**

This authorization is effective for six months unless revoked or terminated by the patient or the patient's representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Family Practice Group. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement of services. You should contact the Office Manager/Compliance Officer to terminate this authorization. The only exception is when action has already been taken in reliance on the authorization.

**Potential for Re-Disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of patient or person authorized by law)

\_\_\_\_\_  
Relationship of Patient Representative to Patient (if signed by other than the Patient)