AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

This is to authorize: _____ Fax:_____

_____ _____
address phone

To release copies my medical record to:
For the purposes of continuing medical care.

Limited to time period of 1-2 years.

GREEN LIFE COMPASSION CLINIC
KENNETH A JACOBS, MD
9220 SW BARBUR BLVD., BOX# 119-162
PORTLAND, OR 97219
503–208–2166: PHONE
503–477–6599: FAX

Please send the records indicated below:

- [X] Clinician office chart notes
- [ ] Transcribed hospital records
- [ ] Most recent three year history
- [ ] Consultations
- [X] Problem list
- [ ] Diagnostic imaging reports
- [ ] Laboratory reports
- [ ] Pathology reports
- [X] Medication list
- [ ] Other: _____

Pertaining to diagnosis of or symptoms relating to: _____

* ***The following items must be initialed by patient to be included in requested chart information (federal regulations require a description of how much and what kind of information is to be disclosed).***

_____ HIV/AIDS related records

_____ Genetic testing information

_____ Mental health information

_____ Drug/alcohol diagnosis, treatment or referral information

Describe: _____

I agree to waive the privilege of confidentiality and privacy of my medical record in order to obtain accurate assessment of my qualification for OMMP licensure. I understand that this is not a blanket authorization to release information. I also understand that these records will not be shared with another facility, organization, individual or medical office without my written permission. This release is intended for one-time use and expires _____ or 3 months after signing. I must re-execute it should additional requests for information occur. I understand that this authorization has been prepared in accordance with OR 433.045 and OAR 333-12-270. I also understand that Oregon Law allows HIV test information to be entered in my medical record and to be seen by or shared orally with persons who must review the record for the purpose of delivering health care to me or for routine administrative purposes. I further understand Oregon Law requires my physician to report my identity and/or HIV antibody test result to Public Health Authorities under certain circumstances without my authorization. I understand that I may revoke this release at anytime by written request.

_____

Patient Signature Date

_____

Signature of lawful representative if patient is incompetent. (Relationship)