

Travel & Immunization Clinic of Portland

2330 NW Flanders Suite 103
Portland, OR 97210

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

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

I authorize Travel & Immunization Clinic of Portland to release a copy of the medical information relating to any and all treatment they have coordinated on my behalf to any physician, insurance company, or shipping agent for the purpose of: billing, patient care, and insurance claims as well as for: _____ .

Additionally I authorize _____ to release a copy of my medical information to Travel & Immunization Clinic of Portland.

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

- | | |
|--|---|
| <input type="checkbox"/> All hospital records | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> Transcribed hospital records | <input type="checkbox"/> Dental records |
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Physical therapy records |
| <input type="checkbox"/> Most recent five year history | <input type="checkbox"/> Emergency and urgency care records |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Billing statements |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diagnostic imaging reports | <input type="checkbox"/> Other _____ |

Please send the entire medical record (all information) to the above named recipient.

- HIV/AIDS related records *(Must be initialed to be included in other documents)*
 Mental health information *(Must be initialed to be included in other documents)*
 Genetic testing information *(Must be initialed to be included in other documents)*
 All drug and alcohol diagnosis, treatment and or referral information.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on authorization. Unless revoked earlier, this consent will expire 2 years from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient Printed Name

DOB

Signature

Date