



## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

*This authorization must be written, dated and signed either 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 treatments they have coordinated on my behalf. The records may be released to any physician, insurance company, shipping agent, or any other third-party for the purpose of billing, patient care, insurance claims, or proof-of-immunizations and/or treatments.

Additionally, I authorize my primary care provider, \_\_\_\_\_, 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 _____                        |

**I authorize the release of my entire medical record (all the information listed above).**

- |                                                                                                 |                                                              |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> HIV/AIDS related records                                               | <i>(Must be initialed to be included in other documents)</i> |
| <input type="checkbox"/> Mental health information                                              | <i>(Must be initialed to be included in other documents)</i> |
| <input type="checkbox"/> Genetic testing information                                            | <i>(Must be initialed to be included in other documents)</i> |
| <input type="checkbox"/> All drug and alcohol diagnosis, treatment and or referral information. |                                                              |

I understand that I may revoke this authorization at any time. If I do not revoke authorization, I understand that this written consent grants the release of medical documents upon request on an ongoing basis.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date