4212 NE Broadway, Portland, OR 97213 Phone (503) 249-8787 Fax (503) 284-5168 www.broadwaymedicalclinic.com

Medical Records Release TO another Provider

I authorize *Broadway Medical Clinic (Dr.)* to disclose a copy of the following patient's health record:

Patient Name: _____ Date of Birth: _____ Phone #: _____

To the following proivder *(please include as much information as possible to avoid delays in processing):*

Clinic: _____

Provider Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

For dates of service:* ◯ *Last two years* ◯ *From _____ /_____ /_____ to present

For the purpose of:* ◯ *Transfer of care* ◯ *Contnuity of care* ◯ *Coordination of care

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials by the applicable space next to the type of information.

____HIV/AIDS information **____Mental health information**

____Drug/alcohol diagnosis, treatment or referral information **____Genetic testing information**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I understand that federal or state law may restrict re-disclosure of the above categories of information. You do not need to sign this authorization. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan for eligibility or benefits, unless the authorization is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this statement, please send a written statement to Broadway Medical Clinic Health Information Management and state that you are revoking authorization.

I have read this authorization and I understand it. Unless revoked or otherwise indicated, this authorization expires in 180 days.

Signed by: _____ Date: _____

Please indicate:* ◯ *Patient or* ◯ *Individual/personal representative-Relationship: _____