AUTHORIZATION FOR EXCHANGE/RELEASE OF MEDICAL INFORMATION, VERBAL OR WRITTEN

(*To be signed by patient or by the person authorized by law to give this authorization*)

Patient: _____ SS# _____ DOB _____
(*Print name of patient*)

Patient Address: _____ Patient Phone: _____

This information will be used for the following purposes: _____
(*Specify for ie:physicians consulting, exchange of information with family member or other.*)

Exchange of information from / to: _____
(*Specify who we can exchange information with.*)

Exchange of information to / from: Oregon Ear, Nose and Throat, PC

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Initial the spaces below to authorize the release of the following information from your patient records and medical care:

___Medical Records Needed for Continuity of Care
___Hearing Tests
___Operative Reports, Hospital Records
___Chart Notes
___Diagnostic imaging reports, Laboratory and/or Pathology Reports
___Other _____
___HIV/AIDS related records (*Must be initialed to be included in other documents.*)
___Mental health treatment related records (*Must be initialed to be included in other documents.*)
___Drug/alcohol treatment related records (*Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form.*)

This consent (unless expressly revoked earlier) is limited to the following time period: _____

Signature of Patient or Legal Representative _____ Date: _____