

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 from/to: 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: _____