

Lake Grove Family Medical Clinic
David Selby, D.O. • Christie Schoppe, PA-C
16463 Boones Ferry Road, Lake Oswego OR 97035
Ph: (503) 635-1350 Fax: (503) 635-8470

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: (_____) _____

I authorize information to be released from:

Lake Grove Family Medical Clinic

Please send my records to:

Name of Facility: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Purpose of Release (Please check appropriate box):

- Changing Primary Care Physician
- Continuation of Care
- Other (Please Specify): _____

Type of information to be released:

- GENERAL medical records (Copies of medical records will be limited to two years of information including lab and imaging unless otherwise requested.)
- SPECIFIC information only:
 - History & Physical (specify date) _____
 - Medications/Therapy _____
 - Lab, Pathology, EKG, X-ray (specify type) _____
 - Operative Report (specify operation) _____
 - Accident or Injury-Dates from _____ to _____
 - Immunizations _____
 - Other _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. By **INITIALING** I authorize the release of the following protected or sensitive information.

_____ Drug Abuse Diagnosis/Treatment
_____ Alcoholism Diagnosis/Treatment
_____ AIDS/HIV Test Results

_____ Sexually Transmitted Diseases
_____ Genetic testing
_____ Mental Health Diagnosis/Treatment

Patient Authorization to Release Information
I understand that by signing I have the right to revoke this authorization at any time.

Signature of Patient or Legally Responsible Person: _____

Relationship to Patient: _____ **Date:** _____