SELLWOOD MEDICAL CLINIC, P.C. Telephone 503-595-9300/ Fax 503-595-9301

3 LOCATIONS:
8332 SE. 13TH
Portland, OR 97202

8333 S.E. 13th Avenue
Portland, OR 97202

6234 N. Greeley Avenue
Portland, OR 97217

Our Providers:
Jennifer Bevacqua,
Naghmeh Moshtael, M.D.
Monique E. Pritchard, M.D
Tara Bernhardt, CPNP
Alison Elia, CPNP
Leslie D. Gregory, PA-C
Brittany Petering, M.D.
Tara A. Schwab, M.D.
Jeanette Haughton, CPNP
Amanda Bailey, M.D.
Kelly Wright, M.D.
Merinda Sterner, PA-C

AUTHORIZATION FOR RELEASE OF INFORMATION from others to Sellwood Medical Clinic, P.C.

PATIENT INFORMATION:

______________________________ DOB: ____________ SS#__________________________

I authorize ____ ← Name of Provider/Facility

____ ← Address of Provider/Facility

____ ← Phone/Fax of Provider/Facility

to disclose my health information specific to the following date or time period______________________

Individual or entity authorized to receive my health information:

Main Location: Sellwood Medical Clinic
8332 S.E. 13th Ave.
Portland, OR 97202
Fax (503) 595-9301

INFORMATION TO BE RELEASED:

- ❑ THE MOST RECENT 2 YEARS OF PERTINENT INFORMATION (CHART NOTES, LABS, X-RAYS,SPECIAL TESTS, IMMUNIZATIONS etc)
- ❑ ALL MEDICAL RECORDS
- ❑ SPECIFIC INFORMATION (PLEASE SPECIFY)____

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE (PLEASE CHECK ONE OF THE FOLLOWING):

- ❑ Attorney
- ❑ Doctor
- ❑ Insurance
- ❑ Personal
- ❑ Transfer of Care

PATIENT AUTHORIZATION—PLEASE INITIAL ALL UNLESS YOU DO NOT WANT MEDICAL RECORDS OF THIS NATURE TRANSFERRED.

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Please initial by any of the following records that you would like included in your medical record. Records that you do not initial cannot be released and may result in an incomplete medical record.-- PLEASE INITIAL ALL UNLESS YOU DO NOT WANT MEDICAL RECORDS OF THIS NATURE TRANSFERRED.

___ Drug/Alcohol abuse/treatment & diagnosis
___ HIV/AIDS diagnosis/Treatment/Testing
___ My Records may be faxed
____ Sexually transmitted diseases
____ Mental illness or psychiatric diagnosis/treatment
____Genetic Testing

MY RIGHTS

I understand I do not have to sign this Authorization in order to be obtain health care benefits (treatment, payment or enrollment). I have the right to revoke this authorization at any time, provided I do so in writing. If I revoke my Authorization my Authorization, the provider will no longer use or disclose information about me for the reasons covered by my written Authorization, but the provider cannot take back any uses or disclosures already made with my permission.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

______________________________ ______________________________
SIGNATURE (OF PATIENT REPRESENTATIVE) RELATIONSHIP (IF SIGNED BY REPRESENTATIVE)

______________________________ ______________________________
(DATE SIGNED WITNESS (OPTIONAL)

THIS AUTHORIZATION WILL EXPIRE 180 DAYS FROM THE DATE SIGNED //COPYING FEE MAY APPLY