# OUTGOING-Records Release

# Oak Street Medical, P.C. and Oregon Allergy Associates

**Phone # 541-431-0000 Fax# 541-344-6176**

I authorize: ___Oak Street Medical ___ Oregon Allergy Associates ___ Jeannie Merrick, WHCNP

To release my medical information to:

Physician, office or person: _____

Address: _____

Phone: _____ Fax#_____

I release the above from all responsibility in regards to the original medical records and ask that you transfer the requested items:

Unless otherwise indicated below this release is for the purpose of **Continuity of Care.**

**___ Transfer of Care; ___ Consult; ___ Insurance; __ Legal; __ Other (list reason) _____.**

My appointment is scheduled for this date: _____.

By **initialing** the space below, I specifically authorize the release of the following medical records:

____ General Medical Records (limited to the last 2 years of available including all skin tests, chart notes, labs and imaging reports unless otherwise indicated). General medical records sometimes contain sensitive information such as alcohol or drug use (not treatment records), mental health concerns (not psychotherapy notes), discussion of HIV testing (not results unless initialed below), sexually transmitted diseases, sexual abuse or sexual orientation and includes family history. By initialing on this option I agree to the release of this type of information.

**OR**

Medical records indicated below for specific date range _____ to _____ or most recent

Please mark specific records requested by placing an X on the lines below.

__Office chart notes __ Lab or Pathology Reports ___ Radiology ___ Immunization Records

__Hospital/ER Reports ___Consultations __ All Skin Tests ___Other _____

**SPECIALLY PROTECTED INFO (MUST BE INITIALED TO BE INCLUDED WITH RECORDS)**

**____GENETIC TESTING INFORMATION (Oregon) ____ DRUG/ALCOHOL TREATMENT**

**____HIV TESTING RESULTS (SEE BELOW) ____ MENTAL HEALTH TREATMENT**

**In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the purpose of release for HIV/HTLV test results/records:**

**___ Transfer of Care; ___ Continuity of Care; ___ Insurance; __ Legal; __ Other (list reason) _____.**

**HIV results may be released from this date_____ until _____ (please enter expiration date).**

**Patient Name: _____ Date of Birth: _____ Other names used by patient: _____**

**Pt. Address: _____ Pt. Phone #: _____**

_____ _____ ____/____/____

**Signature of Patient of Authorized Representative Relationship Date**

**Authorized representative MUST provide legal documentation unless patient is a minor.**

**This release is valid for 1 year or until this date: _____ (valid for a minimum of 30 days to allow for processing).**

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party: or

(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to attention of Privacy Officer at Oak Street Medical, 1488 Oak Street, Eugene, Or. 97401. The notice needs to identify the date you signed this Authorization, the recipient of the information and state the reason that you are revoking this Authorization.

The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

*****Please Note***** There is no charge for records sent to another physician. Your first request for records up to 50 pages is at no charge. After the first 50 pages our normal rates apply. All requests after the first request will be charged at our normal rate of $25 for the first 10 pages and then .25 each additional page. **Please allow up to 30 days to process requests.**

**___ I specifically request that you DO NOT send my personal health information via fax.**