Cascade ID & Infusion

John Girod, MD • Jasmin Chaudhary, MD • Amy Hernandez, PA-C
E.David Shaw, MD • Daniel Campbell, DPM
2720 Commercial St SE, Suite 201 Salem, Oregon 97302
Phone 503-540-9999 • Fax 503-540-3105 • Dr.Shaw 503-480-0485 • Dr. Campbell 503-378-1162

Medical Records Release

Authorization to release medical records per ORS 192.525

This authorization must be written, dated and signed by the patient or by a person authorized by law.

I authorize ______________________ to release a copy of the medical records for:

______________________ (Patient Name) ______________ (DOB)

to the following persons:

______________________ ______________________

______________________ (Name of Person / Place) ______________________ (Address or Business fax #)

These medical records will be used on my behalf for the following reasons:

____.

By INITIALLING the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____ **ALL MEDICAL RECORDS**

____ Chart Notes
____ Diagnostic Imaging Reports
____ Laboratory Reports

____ **OTHER:**

____ HIV / AIDS: Related Records ***MUST INITIAL TO INCLUDE**
____ Mental Health Information ***MUST INITIAL TO INCLUDE**
____ Genetic Testing Information ***MUST INITIAL TO INCLUDE**
____ Drug / Alcohol diagnosis, treatment or referral information: (*Federal Regulations, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed*):

____.

This authorization is limited to the following: ______________________.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request

______________________ Patient or P.O.A. Signature ______________ Date

______________________ Printed Name **AND** Signature of staff member who released records ______________ Date