ASHLAND
FAMILY PRACTICE

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935 SISKIYOU BLVD.
ASHLAND, OR 97520
(541) 482-2716

MEDICAL RECORDS REQUEST

Patient Information

Patient Name:	DOB:
Mailing Address:	
Phone Number:	

Healthcare Facility/Provider who is Releasing Information

Name of Clinic/Provider:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Healthcare Facility/Provider who is Receiving Information

Name of Clinic/Provider: Ashland Family Practice			
Address:	City :	State:	Zip:
935 Siskiyou Blvd.	Ashland	OR	97520
Phone Number (541) 482-2716	Fax Number (541) 488-5461		

Purpose of disclosure: _____ Date Range: From_____ To _____

Type of information to be released (**please check**)

☐ Medication Summary ☐ Progress notes ☐ Diagnostic reports Other: _____

☐ Laboratory reports ☐ Pathology reports ☐ Emergency room reports

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by Federal/State law.

By Initialing, I authorize the release of the following protected/sensitive information

____ Drug abuse diagnosis/treatment ____ Mental health/treatment

____ Alcohol diagnosis/treatment ____ AIDS/HIV/STD & related information

Unless revoked earlier, this authorization will be in effect until _____ or for one year from the date of the signing of this authorization, or shall remain in effect for the period reasonably needed to complete the request. You have the right to revoke this authorization at any time, if you do so in writing and except to the extent that we have already used or disclosed the information in reliance of this authorization. I have reviewed and I under 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 protected under federal law.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name (if other than patient) Relationship to patient