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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____ to release a copy of the medical information
Name of Hospital or Health Care Provider

For _____ to _____
Name of Patient Name and Address of Recipient

The information will be used on my behalf for the following purpose(s) _____

By initialing the space(s) below, I specifically authorize the release the following medical records, if such records exist.

- | | |
|---|-------------------------------------|
| _____ All hospital records (including nursing records and progress notes) | _____ Most recent five year history |
| _____ Transcribed hospital records | _____ Clinical office chart notes |
| _____ Medical records needed for continuity of care | _____ Dental records |
| _____ Laboratory reports | _____ Physical therapy records |
| _____ Pathology reports | _____ Billing statements |
| _____ Diagnostic imaging reports | _____ Other _____ |

- _____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.
- _____ HIV-AIDS related records (must be initialed to be included in other documents.)
- _____ Mental health information (must be initialed to be included in other documents.)
- _____ Genetic testing information (must be initialed to be included in other documents.)
- _____ Drug-Alcohol diagnosis, treatment or referral information as listed on back. (Federal Regulation, 42 CFR part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on the reverse of this form.)

_____ This authorization is limited to the following treatment: _____

_____ This authorization is limited to the following time period: _____

_____ This authorization is limited to workers' compensation claim for injuries of: _____
Date _____

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

Date

Signature of patient or person authorized by law