AUTHORIZATION TO RELEASE INFORMATION FROM MONTEREY HEALTH CENTER

This document provides the authorization for the release of information and/or the request for information as indicated below. Do not sign this release unless it is complete in full and in your best interests. It is also understood that if the person or organization that receives your information is not a health care provider or health insurer the information may no longer be protected by federal regulations. You may inspect and/or have a copy of this authorization and the information being released if you request one.

Medical Records to be sent to:

_____
_____
_____
_____
_____

Medical Records to be sent from:

Monterey Health Center
6975 SE Lake Rd
Milwaukie, OR 97267
Phone: 503.905.2526
Fax: 503.905.2545

Please release the complete medical history and all records pertaining to the care of:

_____
Patient Name

_____
Address

_____
City State Zip

_____ _____
Date of Birth Social Security #

The following must be ***INITIALED*** by the requestor to be included in the use and or disclosure:

_____ Chemical Dependency Information
_____ Mental Health Information
_____ HIV or AIDS information
_____ Genetic Testing Information

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance here on. If not earlier revoked, or by other agreement specified below, this consent shall expire:

☐ Six months from date signed
☐ One year from the date signed
☐ Other (specify) _____

By:_____ Date:_____
(Patient)
Or By:_____ Date:_____
(Patient's Representative)
Description of Representative's Authority:_____

Karl Magsarili, MD • Marcus Cornwall, DO • Pam Rathbone, WHCNP
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