



AUTHORIZATION TO RELEASE INFORMATION

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:

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

Medical Records to be sent from:

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

_____ HIV or AIDS information

_____ Mental Health 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: _____
(Patient)

Date: _____

Or By: _____
(Patient's Representative)

Date: _____

Description of Representative's Authority: _____