MEDICAL RECORDS RELEASE/REQUEST FORM

Patient Name:	DOB:
Address:	Phone:

I authorize the following: (Please check one)

☐ To send records to Elite Primary Care FROM:

☐ To release records from Elite Primary Care TO:

_____

Name of the Provider/Facility

_____

Address

_____ _____

Phone Fax

Purpose of Release: check one box

☐ Transfer of Care/Changing Primary Care

☐ Referral/Consultation

☐ Insurance

☐ Referral/Consultation

☐ Legal

☐ Personal Use/Other

INFORMATION TO BE RELEASED OR REQUESTED

Select one:

☐I ALL HEALTHCARE INFORMATION

☐ I Healthcare information relating to the specified treatment, condition, or dates as follows:

_____

**** I understand and agree that the information to be disclosed may include mental health information, genetic testing information, alcohol/drug dependency information, HIV/AIDS related information, which is either protected by Oregon or other federal law.

I understand and agree that fris protected information WILL BE disclosed UNLESS checked here ☐ ****

I have read and understand the above authorization

Signature:Date:_____ Date: _____

(Patient or Parent/Legal Guardian)