The AC Clinics

9900 SW Greenburg Rd, Suite 235
Tigard, OR 97223

1257 N Riverside Dr, Suite 12
Medford, OR 97501

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

PATIENT PHONE: _____

I authorize: _____ PHONE: _____

(NAME OF PROVIDER/FACILITY/AGENCY)

_____ FAX: _____

(CITY, STATE AND ZIP)

to release a copy of my medical information to:

The AC Clinics, the Medical Offices of:

David Knox, MD • Janice MV Knox, MD • Jessica Knox, MD • Rachel Knox, MD

Tigard Office	Medford Office
FAX: (503) 747-7405	**FAX: (541) 500-8898**

Information will be used for the continuity of patient care relating to the following medical condition(s):

_____

_____

_____

By initialing/checking the spaces below, I specifically authorize the release of the following medical information, if such records exist:

_____ **X** Clinician office chart notes NO OLDER THAN 3 YEARS (regarding condition(s) above)

_____ **X** Diagnostic imaging reports NO OLDER THAN 3 YEARS (regarding condition(s) above)

_____ **X** Emergency & Urgent Care Records

_____ **X** Other: _____

_____ **X** *HIV/AIDS-related records

_____ **X** *Mental health records

_____ **X** *Drug and alcohol-related records

_____ **X** *STD-related records

(Initial Here)

*Must be initialed to be included with other documentation

PERMISSION TO FAX INFORMATION: YES X_____ (Initial Here)

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. 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 to complete the request. I understand that your office will not condition treatment on signing this document, or failure to do so. I further understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

Date: ____/____/_____ Patient Signature: _____