Release of Information

The AC Clinics

1900 US 99 Suite B2
McMinnville, OR 97128

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

Home Office

FAX: (503) 747-7405

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

____

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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: ______________________________