Oregon Lung Specialists, LLC
Pulmonary, Critical Care & Sleep Medicine

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME _____ DATE OF BIRTH _____

I authorize the following facility/entity to release records:

FROM: _____
Facility/Person Phone Number Fax Number

_____
Street Address City/State/Zip Code

TO: _____
Facility/Person Phone Number Fax Number

_____
Street Address City/State/Zip Code

The information will be used on my behalf for the following purpose(s): _____

_____

Information to be disclosed (will be limited to the last 2 years unless specified):

- ☐ Chart Notes
- ☐ Lab Tests
- ☐ Imaging Reports
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ Medication Report
- ☐ Echo/EKG
- ☐ Other (Please Specify):

_____
_____

By initialing in the spaces below, I authorize release of the following information:

_____ HIV/AIDS Related Information
_____ Mental Health Information
_____ Genetic Testing Information
_____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

Release of above information is limited to the following: Time Period _____
Treatment Dates _____
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to **Oregon Lung Specialists, LLC 3125 Chad Drive Ste 100 Eugene, OR 97408**. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the information is disclosed pursuant to this authorization it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulation, but Oregon Lung Specialists will abide by HIPAA law in the disclosure of my medical records.
I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

_____ _____
Signature of Patient Signature of Legal Authorized Person

_____ _____
Date Relationship to Patient

_____
Date

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