Janice M. Vaughn, MD | ACKR Clinic | Fax: 541-730-4147
2300 Ferry St SW, Suite 1 P.O. Box 1398 Albany, OR 97321-0547
Phone: 541-981-2620

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Phone Contact: _____

Need for Review by: _____

I hereby authorize _____
(Name of Individual/Facility/Agency)

_____
(City, State and Zip Code)

Phone: _____ Fax: _____

Please and thank you.

To release a copy of my medical information to:

Janice M. Vaughn, MD
2300 Ferry St SW, Suite 1; PO Box 1398
Albany, OR 97321-0547

PLEASE FAX TO: 541-730-4147

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

_____ Pages documenting the diagnosis of _____

_____ All hospital records (including admission note, discharge summary and progress notes)

_____ Physical therapy records

_____ MRI/X-ray reports/Laboratory reports

_____ Most recent two year history

_____ Emergency and Urgent Care

_____ Entire Medical Record (all information) X Other: Last 2 visits

Purpose of Release Request: Review/Continued Care

I have the right to revoke this Authorization at any time, provided that I do so in writing and except to the extent that I have already used or disclosed the information in reliance on this Authorization.

This authorization is valid for 90 days from signed date or shall remain in effect until _____ unless revoked by the patient orally or in writing at an earlier time.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Signature of Patient: _____ Date: _____