



COLUMBIA GORGE
FAMILY MEDICINE

Authorization for the Release of Records

An Epic Affiliate—Please look for us in Care Everywhere

1750 12th St. Hood River, OR. 97031

Phone: 541-386-5070

Fax: 541-732-3920

Website: www.cgfm.com

Name of Patient:		DOB:		Phone #:	
Address:		City/State:		Zip:	

I AUTHORIZE MY PROTECTED HEALTH INFORMATION TO BE RELEASED:

TO:

Facility/Provider:	
Address:	
City/State/Zip:	
Phone #:	Fax #:

FROM:

Facility/Provider:	
Address:	
City/State/Zip:	
Phone #:	Fax #:

Reason for Request: Personal Legal Transfer of Care Continuity of Care MAIL PICK UP FAX

DATES OF SERVICE _____ **TO** _____ **OR** **ALL MEDICAL RECORDS** **OR** **THOSE SPECIFICALLY CHECKED BELOW**

Last Physical Exam <input type="checkbox"/>	Lab/Pap <input type="checkbox"/>	Colonoscopy/Path <input type="checkbox"/>	Radiology Reports <input type="checkbox"/>
Hospital/Admit/Discharge <input type="checkbox"/>	Progress Notes <input type="checkbox"/>	Immunizations <input type="checkbox"/>	Other <input type="checkbox"/>

State and Federal law protect the following information. Please initial if you would like this information to be released/obtained:

___ Alcohol/Drug Abuse Treatment ___ HIV/AIDS Diagnosis & Treatment ___ Psychotherapy

Parental request for child's records:

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

DATE: _____ **PARENT OR LEGAL GUARDIAN (PRINT NAME)** _____

SIGNATURE: _____

Date: _____ Signature: _____

This authorization expires in a year from the date of the signature unless another date, event or condition is stated.

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