COLUMBIA GORGE
FAMILY MEDICINE

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Authorization for the Release of Records

An Epic Affiliate—Please look for us in Care Everywhere

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 ☐	Lab/Pap ☐	Colonoscopy/Path ☐	Radiology Reports ☐
Hospital/Admit/Discharge ☐	Progress Notes ☐	Immunizations ☐	Other ☐

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.