OREGON SURGICAL WELLNESS
WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give this information

I, _____ _____ _____
Patient Legal Name – Last, First, Middle | Alternative Names Used | Patient Date of Birth

hereby authorize Oregon Surgical Wellness, a division of Willamette Valley Cancer Institute and Research Center, to release and/or disclose the health information as indicated below to the health care provider, entity, or person I have indicated below

At the request of the patient, health information will be released for the following purpose *(✓check all that apply):*

☐ Treatment or Continuing Medical Care
☐ Disability/FMLA
☐ Billing or Claims
☐ Insurance (e.g., Life Insurance Application)
☐ Legal Purposes (e.g., Attorneys)
☐ Personal Use
☐ Other, please describe _____

I authorize medical information to be requested from:

Facility or Individual: _____

Mailing Address (Street, City, State, Zip): _____

Phone Number: _____ Fax Number: _____

I authorize medical information to be sent to:

Facility or Individual: _____

Mailing Address (Street, City, State, Zip): _____

Phone Number: _____ Fax Number: _____

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

_____ Entire Medical Record

_____ Last Two Years of My Entire Medical Record (Excluding Items Found in *Additional Medical Records Request*)

_____ For a Specific Time Period From: _____ to _____

_____ Office Chart Notes	_____ Imaging Reports and/or Films
_____ Pathology Reports	_____ Consultation and H&P Reports
_____ Laboratory Reports	_____ Hospital Reports and Consultations
_____ Radiation Therapy Reports	_____ Attending Physician Statement and/or FMLA
_____ Billing and Account Summary	_____ Other, Please Specify _____

OSW/WVCI STAFF USE ONLY

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Additional Medical Records Request: I understand federal or state laws may restrict disclosure of information pertaining to HIV/AIDS, mental health, genetic testing, and drug/alcohol diagnosis, treatment or referral. By initialling the spaces below, by initialing the spaces below I specifically authorize the release of the following health information:

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

I understand that:

- My health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I may revoke this authorization at any time by notifying Oregon Surgical Wellness in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
- This authorization will expire 180 days from the date of signing or on the expiration date noted below, if earlier.

_____ _____
Please Specify the Event or a Date That Triggers the Expiration — Expiration Date

Signature

_____ _____
Signature of Patient or Personal Representative — Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____
Name of Personal Representative — Date

WVCI STAFF USE ONLY

DATE RECIEVED: _____

RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____

PATIENT IDENTITY AND AUTHORITY VERIFIED ☐ FEES EXPLAINED IF NEEDED ☐

RECORDS SENT BY: _____ DATE/TIME: _____