

## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

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

I authorize \_\_\_\_\_ to release a copy of the medical information for  
(provider name) Meridian Park Radiation Oncology Center  
6489 SW Borland Rd. Tualatin, OR 97062  
\_\_\_\_\_ to p. 503-692-4843 f. 503-692-6543  
(name of patient) (name and address of recipient)

The information will be used on my behalf for the following purpose(s):  
RADIATION TREATMENT and ongoing care for current diagnosis.

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

- |  |   |
|--|---|
| <input type="checkbox"/> All hospital records (including nursing records and progress notes) | <input type="checkbox"/> Diagnostic imaging reports         |
| <input type="checkbox"/> Transcribed hospital reports  | <input type="checkbox"/> Clinician office chart notes       |
| <input type="checkbox"/> Medical records needed for continuity of care                       | <input type="checkbox"/> Dental records                     |
| <input type="checkbox"/> Most recent five-year history                                       | <input type="checkbox"/> Physical therapy records           |
| <input type="checkbox"/> Laboratory reports  | <input type="checkbox"/> Emergency and urgency care records |
| <input type="checkbox"/> Pathology Reports   | <input type="checkbox"/> Billing statements                 |
|  | <input type="checkbox"/> Other                              |

Please send the entire medical record (all information) to the above named recipient.

*The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.*

\*HIV/AIDS-related records

\*Mental health information

\*Genetic testing information

\*Must be initialed to be included in other documents.

\*\*Drug/alcohol diagnosis, treatment of referral information as follows:

\_\_\_\_\_  
\*\*Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

This authorization is limited to the following treatment: \_\_\_\_\_

This authorization is limited to the following time period: \_\_\_\_\_

This authorization is limited to a workers' compensation claim for injuries of \_\_\_\_\_

\_\_\_\_\_  
(date)

*This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.*

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of person authorized by law)

updated 5-27-08 ah