Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225
Office 503.216.5380
Fax 503.216.5399
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Amanda M. McClure, MD
Colon and Rectal Surgeons

AUTHORIZATION FOR THE RELEASE OF PATIENT MEDICAL RECORDS

Send To: NW Center for Colorectal Health, LLC
9155 SW Barnes Rd., Suite 231, Portland, OR 97225
Fax. 503-216-5399

Re: Patient name:______________________________

Date of birth:______________

I authorize and request the disclosure of all protected information for the purpose of (reason):

<u>Continuation of care</u>______________________________

I expressly request that the designated record custodian disclose full and complete protected medical information including the following **(initial each item to be included):**

<u>NOTE: ONLY THOSE ITEMS INITIALED WILL BE INCLUDED IN THE RELEASED INFOMATION</u>

___ All hospital records
___ Transcribed hospital records
___ Medical records needed for continuity of care
___ Lab reports
___ Path reports
___ Diagnostic imaging reports

___ Most recent five year history
___ Clinician office chart notes
___ Dental records
___ Physical therapy records
___ Billing statements
___ Other ______________

___ HIV/AIDS related records
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment or referral information as listed on back (Federal Regulation 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form)

___ Send the entire medical record (all information) to the above named recipient.

This authorization is limited to the following treatment(s):______________________________

This authorization is limited to the following time period:______________________________

This authorization is limited to work comp claim for injuries incurred on ______________
Date

This authorization may be revoked at any time (in writing) except to the extent information has been released in reliance upon this authorization.

______________ ______________________________
Date Signature of patient or legally authorized representative