New Heights
PHYSICAL THERAPY +

5736 NE Glisan St. Portland, Oregon 97213 Phone 503. 236.3108 Fax 503.236.3239

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Other Name _____

Birthdate: _____

Current Address: _____

Daytime phone # _____ Alternate phone #_____

Reason for Record
- ☐ Personal
- ☐ Medical Care
- ☐ Benefits
- ☐ Litigation
- ☐ Workman's Comp

I AUTHORIZE INFORMATION RELEASE FROM

_____
Name of Facility

_____
Name of Physician

_____
Address, City, State, Zip

PLEASE SEND MY RECORDS TO

_____
Facility to Receive Information

_____
Title (Physician, Physical Therapist, Healthcare Facility, etc)

_____
Address, City, State, Zip

Type of Information to be Released

☐ Chart Notes ☐ X-Ray Reports ☐ MRI Reports ☐ Surgery Reports ☐ Physical Therapy

☐ Lab Results ☐ Other: _____

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV / AIDS Information *Initials*

_____ Genetic testing information *Initials*

_____ Mental health information *Initials*

_____ Drug / Alcohol diagnosis, treatment, or referral information *Initials*

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing in formation and drug/alcohol diagnosis, treatment or referral information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except: to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) _____

Signature of Patient or Patient's Legal Representative **Date**

Print Patient's Name or Name of Patient's Legal Representative (if applicable) **Relationship to Patient**

☐ ***Patient's or Legal Representative's Personal Identification Verified***