

Mothers Against Misuse and Abuse Clinic

PO Box 1698 The Dalles, OR 97058 phone: 503-233-4202 OR 541-298-4202 fax: 866-559-3369

PERMISSION TO RELEASE MEDICAL RECORDS & MEDICAL INFORMATION

Please fill out this form carefully and completely. Much of the information is REQUIRED by Federal and State Law to comply with your release request.

Patient Name: _____ DOB: _____

Address: _____

Day Phone: _____ Home: _____ SS#: _____

I authorize information to be released FROM:

Name of Facility/Doctor: _____

Street Address: _____

State: _____ Zip: _____ Phone _____ FAX: _____

I authorize information to be released TO:

MAMA Clinic - Medical Records Dept.

PO Box 1698

The Dalles, OR 97058

Phone: 541-298-4202 Fax: 866-559-3369

This information will be used for the following purposes:

Patient Care _____ Legal Review (type and date of injury)
 Medical Review _____ Other _____

INITIAL type of information to be released:

___ All records (limited to 2 years) pertaining to my diagnosis of _____
___ Physician notes and records (limited to 2 years of information and excludes protected records.)
___ HIV / Aids Information
___ Other (specify information and dates) _____

Expiration: Unless revoked in writing, this authorization expires 180 days from the date of signature.

FAXING limits: Please limit faxed records to **20 pages**. All other records may be submitted by mail in hard copy or digitally as a PDF on a CD. **MAMA does not pay for medical records.**

Disclosure Statement: I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of the "Sender" or you. This information may not be protected by Federal privacy regulation.

Disclaimer: Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. Release of this information in your general medical record requires additional authorized signatures.

FAX Authorization: I specifically give authorization to FAX my medical information. I understand the risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

Patient's signature (or legally responsible person - state relationship to patient)

Date