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
clinic@mamas.org **http://www.mamas.org**

This information will be used for the following purposes:

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

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