Authorization for Release of Medical Information

I understand that my records are protected under State and Federal confidentiality laws and require my written consent for release.

I authorize release **From** : ----------

I authorize release **TO** : ----------

I authorize release of the following records:

( ) All records-see #4 below
( ) Only records from (date)
( ) Only records pertaining to (problem)

---------- ---------- ----------
Date Signature of patient or legal guardian Date of Birth

I specifically authorize release of the following information :
( ) Alcohol/Drug treatment
( ) Mental Health Treatment
( ) Sexually transmitted disease treatment
( ) HIV/AIDS testing results

You have the right to revoke this authorization at any time by written request. Please address your request to the records custodian @ 7215 SE Milwaukie Ave, Portland OR 97202.
This authorization will expire on the earlier of----------(date), 180 days from the date of signing.

I have reviewed and understand this authorization. I also understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: ---------- **Date** : ----------
patient