Siskiyou Family Health
1025 Siskiyou Blvd
Ashland, Oregon 97520
Phone: 541-488-0873 Fax: 482-6037

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, upon appropriate completion of this authorization.

Last Name	First Name	MI	Date of Birth
Phone Number	Street Address		City, State, and Zip Code

Purpose of release: □ Continuation of Care □ Personal Reasons □ Insurance
□ Other _____

There is a copy charge of $35.00 for records released to individual patients. There is no charge for records sent to another provider.

Release the information from:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Disclose the information to:
Name: Siskiyou Family Health
Address: 1025 Siskiyou Blvd.
Ashland, Oregon 97520
Phone: 541-488-0873
Fax: 541-482-6037

Requested medical information: (check those that apply)

□ Entire medical records □ Lab Reports □ Pathology

□ Last 5 years □ Radiology □ Other _____

□ Last 3 years □ Hospital **PLEASE MAIL IF MORE 25 PAGES**

□ Progress Notes □ Health History

I give special permission to release any information regarding: (initial on applicable line(s) below)

_____ Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

Signature _____ Date _____

Witness _____ Date _____

NOTE: While Siskiyou Family Health office and its member organizations makes every effort to protect the privacy of your medical information, please note that the release of your medical information to the authorized person or organization could be the subject of redisclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPPA") or other federal or state laws. This authorization will expire within 90 days unless you specify otherwise.