

# Junction City/Harrisburg Clinic Medical Records Release



355 W 3rd Ave  
Junction City, OR 97448  
Ph: 541 998-6750 Fax: 541 998-1247

## PLEASE PRINT AND COMPLETE ALL SECTIONS

I authorize information to be released

FROM: \_\_\_\_\_

Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Please send my records

TO: \_\_\_\_\_

Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

### PURPOSE OF THIS RELEASE:

Medical Care  Transfer of Care  Relocating  Legal  Request of the Individual  Other

### TYPE OF INFORMATION TO BE RELEASED:

All Medical Records (Last two years unless otherwise requested.)

Physician Notes

X-Ray Reports

Lab and/or Pathology Reports

Hospital Records/Consultants

Physical Therapy Records

Other \_\_\_\_\_

\*\*\*Must be initialed to be included in other documents\*\*\*

HIV/AIDS related records

Mental Health-counseling and/or treatment information.

This includes information regarding depression, anxiety and stress.

Drug/alcohol diagnosis, treatment or referral information

(Federal regulation 42CRF Part2, required a description of how much and what kinds of information is to be disclosed.)

If applicable, complete the restriction box below.

**Restrictions**-Initial and Complete if applicable:

This authorization is limited to the following time period: \_\_\_\_\_

This authorization is limited to the following treatment: \_\_\_\_\_

## PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

PO Box or Street

\_\_\_\_\_  
City, State, Zip Code

Phone Number: \_\_\_\_\_

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 Junction City/Harrisburg Medical Clinics or you. I understand that I can cancel my permission to disclose my information at any time in writing. This information may not be protected by Federal Privacy regulation. Unless otherwise requested, the duration of this consent to Junction City/Harrisburg Medical Clinic will be six months following the date of signature.

The purpose of this release is for ongoing medical care. Unless specifically requested, we will only release records generated by Junction City/Harrisburg Medical Clinics.

The recipient of these records cannot transfer them to another party without consent from the patient or authorized representative, except for purposes of treatment, payment or operations.

As a courtesy, we will forward your medical records to other physicians. Records requested for personal use will incur a \$25.00 fee for the first 10 pages and .25 cents per page thereafter.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date



























