

Junction City Harrisburg Medical Clinic Record Release Form

Send Records to:

Junction City Medical Clinic

355 W 3rd Avenue, Junction City, OR 97448

Ph (541) 998-6750, Fax (541) 998-1247

Patient Name (please print)

_____/_____/_____
Date of Birth

Other Names Used

()

Phone Number (where you can be reached)

I authorize Junction City Harrisburg Medical Clinic to do the following (please check one box only):

Provide Medical Records to:

Receive Medical Records from:

Facility/Person

()
Phone Number

()
Fax Number

Street Address

City, State, Zip Code

Medical Records Released for the following purpose:

Changing of PCP

Continuation of Medical Care

Billing Issues

Other _____

Please send the past 2 years of clinical notes, lab reports, diagnostic tests, and operative reports.

Additionally, I especially request records regarding: _____

I understand that:

The purpose of this release is for on-going medical care.

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

Unless specifically requested, we will only release records generated by Junction City Harrisburg Medical Clinics.

This authorization will expire in 60 days and can be revoked in writing at any time.

General medical records sometimes contain reference to drug use, alcohol use, rehabilitation treatment, psychiatric treatment, sexual abuse, and other sensitive issues. I agree to release these records.

Please note, there is a \$25.00 charge for the 1st 10 pages and \$0.25 per page thereafter for personal copy requests.

Signature of Patient or Authorized Representative

_____/_____/_____
Today's date

I further authorize that all psychiatric, drug, alcohol, Acquired Immunodeficiency Syndrome (AIDS) or HIV/HTLV test results/records be released to the above. In accordance with Oregon State law (OAR333 12-270 Sub 8) you are required to state the PURPOSE of RELEASE of HIV/HTLV test results/records:

The HIV/HTLV test results may be released from _____ up to and including _____ .
Today's date Future date

Signature of Patient or Authorized Representative

_____/_____/_____
Today's date

Please return a copy of this form with records