



# Cascade Infectious Diseases and Infusion

## MEDICAL RECORDS RELEASE / REQUEST

Authorization to release medical records per ORS 192.566

This authorization must be written, dated and signed by the patient or by a person authorized by law

I do hereby consent and authorize Cascade ID & Infusion to release / request copies of my medical records.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

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

Contact Phone: \_\_\_\_\_

To the following Person(s) and/or to Physician's Office:

*note: If addresses are not provided, it may cause a delay in your request.*

Name of Dr. / Person: \_\_\_\_\_ Dr. Office/Facility Name: \_\_\_\_\_

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

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

Phone # \_\_\_\_\_

FAX # \_\_\_\_\_

Duration of Records Request:

Most Recent Visit

Last 2 years

Medical Records from \_\_\_\_\_

to \_\_\_\_\_

Please **check** all the specific medical record documents that apply to your request:

Dr. Visit Notes

Cultures

Billing Statement

Lab Results

Imaging Reports

Entire Medical Chart

Pathology Results

Nurse Notes

Please place your **initials** besides the option below to authorize sensitive information pertaining to:

HIV/AIDS \_\_\_\_\_

*Please note: Mental Health, Genetic Testing & Drug and Alcohol related information must be obtained by your Primary Care Physician.*

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

Signature of Patient or Legal Representative \_\_\_\_\_  
(refer to **consent to release information** form for verification of signature)

Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

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