Cascade
Infectious Diseases
A Practice of Oregon Specialty Group

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 Infectious Diseases 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
- ☐ Lab Results
- ☐ Pathology Results
- ☐ Cultures
- ☐ Imaging Reports
- ☐ Nurse Notes
- ☐ Billing Statement
- ☐ Entire Medical Chart

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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