White Bird Medical Clinic
1400 Mill Street, Eugene, Oregon USA 97401
Telephone 541-484-4800 Fax 541-344-8351

White Bird Medical Clinic is a not-profit organization that does not have the resources to pay for copies of records. For this reason, we ask that you waive any customary fees for copies. Please call if you have questions, and we thank you in advance.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's name: _____ Patient's date of birth: ___/___/_____

I authorize _____(phone number: _____, fax number: _____)
to send a copy of my medical records, as specified below, to:

White Bird Medical Clinic
FAX 541-344-8351
1400 Mill Street, Eugene, Oregon USA 97401
Telephone 541-484-4800

Please release the following information for dates from _____ to _____:

□ **Preferred: Current problem list + current med list + most recent clinic note + labs/imaging reports for past year**

And/Or:

□ Outpatient Clinic Notes
□ Immunization Records
□ Hospital Admission History and Physical
□ Hospital Discharge Summary
□ Hospital Progress Notes
□ Operative Reports
□ Specialist Consultant Reports/Correspondence
□ Lab Reports
□ Pathology Reports (biopsy, Pap, colonoscopy, etc.)
□ Imaging Reports (ultrasound, x-ray, CT, MRI, etc.)
□ Therapy Notes
□ Special test results: ECG, EEG, EMG, etc.

Purpose of requested information:

☒ Continuity of care with new physician
□ Out of town move
□ Legal/disability case
□ Insurance issue
□ Personal
□ Other: _____

Unless limited below, my records may include information about drug or alcohol use, sexually transmitted infections including HIV/AIDS, and psychiatric conditions.
I may limit the information to keep some parts of my records from being released.

Limitations, if any:

□ Please release only summary information (not detailed information) regarding the following condition/s:

□ Please release only the following specific information: _____

I UNDERSTAND THAT ***I MAY REVOKE THIS REQUEST AT ANY TIME***
by making a written request to "Office Staff" at White Bird Medical Clinic (address above).
THIS REQUEST EXPIRES ONE YEAR AFTER THE DATE OF SIGNING, unless revoked.

Signature: _____ Date signed: ___/___/_____

□ Parent/guardian (Relationship to patient: _____)

□ Witness (Patient unable to sign; Reason: _____)

Updated: July 5, 2017