Primary Care West, PC
1255 Wallace Rd NW Salem, OR 97304
Tel 503-362-1314 | **Fax** 503-362-5895
http://primarycarewest.com

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Name_____ DOB_____

**********Please include other names used at PCW**********Please write legibly********

I hereby Consent and Authorize Primary Care West, PC to:

1. CHECK ONLY ONE

_____ **Send/give** a copy of my specific health information to person or organization named below.
_____ **Receive** a copy of specific health information from person or organization named below.
_____ **Orally** exchange specific health information with person or organization below.

2. CONSISTING OF (check all that apply)

_____ Entire Medical Record _____ Physical therapy records _____ Lab reports
_____ Most recent Annual and Pap _____ Diagnostic imaging reports _____ Pathology report
_____ TB information, including X-ray report if applicable _____ Immunizations
_____ Other _____

To /From

Name_____

Address_____ Telephone_____

City/State/Zip_____ Fax_____

FOR THE PURPOSE OF: (describe purpose of disclosure) ☐ Continuity of Care ☐ Transfer of Care
☐ Other_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **INITIALS** in the applicable space next to the type of information.

*** ***The following must be initialed in order for it to be included in your request.***

_____ HIV/AIDS information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Genetic testing information
_____ Mental health information

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Primary Care West PC, 1255 Wallace Rd, Salem, OR 97304 and state that you are revoking this authorization.
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or until (please specify) _____.
If I fail to specify an expiration date or event, this authorization will expire one year form the date on which it was signed.

_____ _____ _____
Signature of individual or personal representative Date Your Telephone