INCOMING-Records Release

Pain Management Partners

2401 River Road Suite 101, Eugene Or 97404
Phone # 541-344-8469 Fax# 541-687-8631

I authorize (physician, office or person): ____
Address: ____
Phone: ____________________________ Fax#________________________________

To release my medical information to: Pain Management Partners

Unless otherwise indicated below this release is for the purpose of **Continuity of Care.**
___ Transfer of Care; ___ Consult; ___ Insurance; __ Legal; __ Other (list reason) _________________________.

Patient has an appointment with our office on ___________. Please send records before appointment.

By **initialing** the space below, I specifically authorize the release of the following medical records:
____ General Medical Records (limited to the last 2 years available including all skin tests, chart notes, labs and imaging reports unless otherwise indicated). General medical records sometimes contain sensitive information such as alcohol or drug use (not treatment records), mental health concerns (not psychotherapy notes), discussion of HIV testing (not results unless initialed below), sexually transmitted diseases, sexual abuse or sexual orientation and includes family history. By initialing on this option I agree to the release of this type of information.

OR (if you initialed "general records release" above, do not select any options below. If you did not initial "general records release" above, please select the items you wish to release below)

Medical records indicated below for specific date range ___________ to ___________ **OR** ___ All Records
Please mark specific records requested by placing an X on the lines below.

__Office chart notes __ Lab or Pathology Reports ___ Radiology ___ Immunization Records
__Hospital/ER Reports ___Consultations __ All Skin Tests ___Other _________________

SPECIALLY PROTECTED INFO (MUST BE INITIALED TO BE INCLUDED WITH RECORDS)
____GENETIC TESTING INFORMATION (Oregon) ____ DRUG/ALCOHOL TREATMENT

____HIV TESTING RESULTS (SEE BELOW) ____ MENTAL HEALTH TREATMENT

In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the purpose of release for HIV/HTLV test results/records:
___ Transfer of Care; ___ Continuity of Care; ___ Insurance; __ Legal; __ Other (list reason) _________________________.

HIV results may be released from this date_____________ until _______________ (please enter expiration date).

Patient Name: __________________________ Date of Birth: __________ Other names used by patient: ___________

Pt. Address: ____ Pt. Phone #: _________________________

____ __________________ ____/____/____
Signature of Patient or Authorized Representative Relationship Date
Authorized Representative MUST provide legal documentation unless patient is a minor.

This release is valid for 1 year or until this date: _______________ (valid for a minimum of 30 days to allow for processing).

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party: or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to attention of Privacy Officer at Pain Management Partners, 2401 River Road Suite 101, Eugene, Or. 97404. The notice needs to identify the date you signed this Authorization, the recipient of the information and state that you are revoking this Authorization.
The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law. **Please allow 30 days for requested information to arrive in our office.**

_____ I specifically request that you DO NOT send my personal health information via fax. This release form will be faxed to expedite