REDDY
Family Medicine

2840 Crescent Ave, Suite 500 Eugene, OR 97408
Phone 541-743-1588 Fax 458-234-4460

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient	Birthdate
Address	
Phone Number	E-mail

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, or employer, to release all health information about me:

Person/Organization to Release Information	
Address	
Phone Number	Fax Number

The following persons/organizations are hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Release Information Reddy Family Medicine	
Address 2840 Crescent Ave., Suite 500 Eugene, Oregon 97408	
Phone Number 541-743-1588	Fax Number 458-234-4460

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ [Date] to _____ [Date], may be released:

- Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually-transmitted diseases, tuberculosis, or hepatitis
- Treatment related to AIDS/HIV
- Mental health treatment or psychological conditions
- Alcohol or substance abuse treatment
- Genetic testing
- Other: _____

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

☐ Change of Doctor ☐ Other _____

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

_____

Patient's or Representative Signature Patient's Name Date