MEDICAL RELEASE

875 Oak St. SE
Bldg. C, Suite 5060
Salem, Oregon 97301
Phone: 503-399-1386
Fax: 503-399-1182

CAPITAL NEUROSURGERY SPECIALISTS

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I AUTHORIZE INFORMATION RELEASE FROM:

Name of Facility/Provider: ______________________________

City, State, Zip : ______________________________

I AUTHORIZE INFORMATION RELEASE TO:

Name of Facility/Provider: ______________________________

City, State, Zip : ______________________________

Type of Information to be Released

- ☐ Clinic Chart Notes
- ☐ Laboratory & Pathology Reports
- ☐ Billing Statements
- ☐ All Medical Records
- ☐ Diagnostic Imaging Reports
- ☐ Physical Therapy Records
- ☐ Medical Records from ________ to ________
- ☐ Hospital Operative Reports
- ☐ Most Recent 5 Year History
- ☐ Other

***Note: If check box is not selected, any records your provider feels necessary for your care will be copied/printed.*

How will the records be released:

☐ Mailed ☐ Faxed ☐ Unsecured Email ☐ Email Address: ______________________________

If records are to be released by way of unsecured email it is important that you understand the risks that are associated with this method of transmission. I have been informed of the risks involved when using unsecured email and I authorize release of the above-named records via email.

Purpose of Release:

☐ Continuing Care ☐ Copies for own use ☐ Legal ☐ Transfer to another provider ☐ Other: ____________________

Protected or Sensitive Information: 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.

_______ HIV/AIDS Information
Initials

_______ Mental Health Information
Initials

_______ Drug/Alcohol Diagnosis, Treatment or Referral Information
Initials

_______ Genetic Testing Information
Initials

I understand that the information used of disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that the federal or state law may restrict re-disclosure of HIV/ AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

PATIENT INFORMATION: 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment. 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. Any use or disclosure already made with your permission cannot be undone. This authorization will expire 1 year from the date signed below unless another date or event is entered here _____________.

To revoke this authorization, please send a written statement declaring that you are revoking this authorization to: Capital Neurosurgery Specialists
Attention: Medical Records, 875 Oak St. SE, Suite # 5060 Salem, OR 97301.

Print Name: ______________________________ Date of Birth: ____________________

Patient Signature or Authorized Representative: ______________________________ Date: ____________________