



**AUTHORIZATION TO
RELEASE MEDICAL INFORMATION (Oregon)**

*****For Office Use Only*****

Date Received: _____ Date Information Released: _____

Copy of verification of identity of individual and/or legal representative obtained/filed.

Notes: _____

Medical Record Number

Clerk Initials

*****Revocation of Authorization*****

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

- Above Authorization
- Authorization releasing information to _____
- Authorization dated _____

Signature: _____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: _____

*****For Office Use Only*****

Date Revocation Received: _____

Medical Record Number

Clerk Initials

Exceptions:

The exceptions noted in the Rights section on front of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.