

WEST LINN FAMILY HEALTH CENTER

DAVID B. FARLEY, M.D.

JOYCE S. ENDO, M.D.

RYAN G. SCOTT, M.D.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

RELEASE FROM: (check appropriate box or fill in info)

Physician name: _____

West Linn Family Health Center
18380 Willamette Drive Ste. 202
West Linn, OR 97034
Phone: 503-635-8384
Fax: 503-636-6475

Facility Name _____
Address _____
City,State,Zip _____
Phone _____
Fax _____

RELEASE TO: (check appropriate box or fill in info)

Name: _____
Name of person receiving information

_____ Title (patient, spouse, physician, attorney, etc.)

West Linn Family Health Center
18380 Willamette Drive Ste. 202
West Linn, OR 97034
Phone: 503-635-8384
Fax: 503-636-6475

Facility Name _____
Address _____
City,State,Zip _____
Phone _____
Fax _____

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Patient Name Date of Birth

Purpose for Release: transfer of care
 continuous release to patient (lab results, etc.)
 communication purposes (with spouse/parent etc.)
~This request expires one year from date this form is signed~
 other: _____

Information to be Released: all medical records
 other: _____

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
Patient or Guardian Signature
Guardian Relationship _____

Date request completed _____ By _____