Willamette Valley Cancer Institute and Research Center (WVCI)

520 Country Club Road Eugene, OR 97401 (541) 683-5001 Fax – 541-683-1422
444 NW Elks Drive Corvallis, OR 97330 541-754-1256 Fax 541-597-1472

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

______________________	______________________
Patient Name	**Date of Birth**
Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
______________________	______________________
Person/Organization Name	Person/Organization Name
______________________	______________________
Address	Address
______________________	______________________
City, State, Zip Code	City, State, Zip Code
______________________	______________________
Phone Number Fax Number	Phone Number Fax Number

I hereby authorize ______________________ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The information will be released, at the request of the patient, for the following purpose:

____

By ***initialing*** the spaces below, I authorize the release of the specified medical records. This may include information contained in my medical record that was provided to WVCI from another health care provider or facility. Further, by signing this Authorization form, it is understood that WVCI may continue to release information or copies of medical records to the above named party, as may be requested, through the expiration date noted below.

_____ Office Chart Notes
_____ Pathology Reports
_____ Radiation Therapy Reports
_____ Consultation and H&P Reports
_____ Billing / Account Summary
_____ Hospital Reports & Discharge Summaries
_____ Laboratory Reports
_____ X-Ray Reports
_____ Medication Flow Sheet
_____ Social Work Information
______ Psychotherapy Notes
______ HIV Test Results
_____ Entire Medical Record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).
_____ Attending Physician Statement/FMLA
_____ Other, Please Specify ______________________________________

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws. I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. **This Authorization will expire one hundred eighty (180) days from the date of signing or notification that disability benefits have ended.**

______________________ ______________________
Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

______________________ ______________________
Name of Personal Representative Relationship to Patient