

**WEST LINN FAMILY HEALTH CENTER, P.C.**

18380 WILLAMETTE DRIVE, SUITE 202 - WEST LINN, OREGON 97068-1718 - PHONE (503) 635-8384 - FAX (503) 636-6475

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**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 97068  
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**  
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West Linn, OR 97068  
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

**Purpose for Release:**  transfer of care  other: \_\_\_\_\_

**Information to be Released:**  all medical records  other: \_\_\_\_\_

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 **only if I place my initials in the applicable space** next to the type of information.

\_\_\_\_ Genetic testing information      \_\_\_\_ Mental health information  
\_\_\_\_ HIV/AIDS information              \_\_\_\_ Drug/Alcohol Treatment

You may revoke this authorization in writing at any time except to the extent that our office has already acted on this authorization. To do so, submit a written request stating that you are revoking this authorization to WLFHC, 18380 Willamette Dr. Ste 202, West Linn, OR 97068.

Unless revoked, this authorization expires 365 days from date of signing.

***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: \_\_\_\_\_ Guardian Relationship: \_\_\_\_\_  
Patient or Guardian Signature

Office use only:  
Date request completed \_\_\_\_\_ By \_\_\_\_\_