GreenField Health

WESTSIDE | 9450 SW Barnes Road, Suite 100
Phone: 503-292-9560 Fax: 503-292-9510

EASTSIDE | 700 NE Multnomah, Suite 400
Phone: 503-292-9560 Fax: 503-517-8792

Authorization to Release Medical Information

Patient Last Name (PLEASE PRINT)	First Name	M.I.	D.O.B.	SSN #
Former Name (if applicable)	Home Phone		Cell Phone	

I Authorize Information to be Released From:

GreenField Health – Dr. _____
9450 SW Barnes Road, Suite 100
Portland, OR 97225
Fax: 503-292-9510

GreenField Health – Dr. _____
700 NE Multnomah St, Ste 400
Portland, OR 97232
Fax: 503-517-8792

Please Send My Records To:

Physician Name	Facility Name	
City/State	Phone Number	Fax Number

Purpose of Release: ☐ Changing Primary Care Physician/Clinic ☐ Other: _____

☐ General Medical Records
☐ Specific Information Only (please specify types of records, dates of service and/or specific health condition:

_____

The following items must be initialed to be released:

_____HIV-positive test results and HIV diagnosis
_____Mental Health records
_____Genetic Testing records
_____Sexually Transmitted Diseases records
_____Drug Abuse records
_____Alcohol Abuse records

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in 90 days.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name Relationship to Patient