GreenField Health
WESTSIDE | 9450 SW Barnes Road, Suite 100 EASTSIDE | 700 Multnomah, Suite 400 Phone: 503-292-9560 | Fax: 503-292-9510

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Separate form required per each previous provider)

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:

Physician Name	Facility Name	
City/State	Phone Number	Fax Number

Please Send My Records To: (circle correct location)

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

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

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