TIGARD ORTHOPEDIC & FRACTURE CLINIC

Release of Information

Patient Name: _________________________________ DOB:___________________

Phone number:_________________________________

RELEASE OF MEDICAL RECORDS TO OUTSIDE PROVIDER:

I request that a copy of my medical record be released directly to: (sign below)

Name: ____

Address: ____

City, State, Zip: ______________________________________

FAX: ____

OR
AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION:

I authorize Tigard Orthopedic & Fracture clinic to discuss/disclose/grant to the following individuals:

______________________________________ Relationship__________________
______________________________________ Relationship__________________
______________________________________ Relationship__________________

☐ ALL MEDICAL AND HEALTH INFORMATION INCLUDING SCHEDULING PRIVILIGES AND FINANCIAL INFORMATION
☐ Medical & Health Information
☐Financial Information
☐ Scheduling privileges and information

I may revoke this authorization at any time by notifying Organization in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by TOFC before TOFC received my written notice of revocation. Unless earlier revoked, this authorization will expire ☐**30 days** ☐**60 Days** ☐**120 Days,** from the date signed.

Signature ___________________________________ Date __________________________