



2236 SE Belmont Street • Portland, Oregon • 97214
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 prismhealth.org

RELEASE OF INFORMATION

Date: _____

PATIENT INFORMATION			
Last Name:	First Name:	Middle Initial:	
Address:		Apt:	Date of Birth:
City:	State:	Zip:	Phone:
RELEASE INFORMATION FROM:			
I hereby authorize the physician/facility listed below to share my individually identifiable health information, which may include protected or privileged information to Prism Health:			
Facility or Provider Name:			
Address:		Phone Number:	
City:	State:	Zip:	Fax Number:
INFORMATION TO BE DISCLOSED			
Please check what information you want released (check all that apply):			
<input type="checkbox"/> My records for medical treatment from the following time period: _____ to _____			
<input type="checkbox"/> Most recent laboratory results <input type="checkbox"/> All laboratory results			
<input type="checkbox"/> All medical records <input type="checkbox"/> Other records: _____			
<input type="checkbox"/> Release is to EXCLUDE the following: _____			
PURPOSE			
<input type="checkbox"/> Continued care by another provider <input type="checkbox"/> Insurance claim <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Legal Reasons			
<input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____			
SENSITIVE INFORMATION			
All records will be released to the named person or organization listed above. This includes details of mental health treatment, substance abuse treatment, and HIV/AIDS related information. If you do NOT want one of the for mentioned categories released please fill out the section below.			
I do NOT want the following records released:			
<input type="checkbox"/> Mental Health Treatment <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> HIV/AIDS Related Information			
RELEASE AND EXPIRATION OF ROI			
Unless you specify otherwise, this Release of Information will expire after 12 months from the date it was signed. If you would like this Release of Information to expire sooner than 12 months please specify the date you would like it to expire: _____			
I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. This authorization may include disclosure of information relating to mental health treatment, substance abuse treatments, and HIV/AIDS related information unless I indicated otherwise. I understand that this Release of Information will expire 12 months from the date it is signed unless I indicated otherwise. If at any time I change my mind and want to revoke this Release of Information, I must contact Prism Health in writing to make the request. This form is not valid unless it is signed at dated by the patient.			

Patient Printed Name			

Patient Signature		Date	