**Cascade Medical Care, LLC**

**RECORDS RELEASE**

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| **PATIENT INFORMATION** | **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Clinic/Hospital/Health Care Provider** – (Who has the information you want released?) Please list the specific Hospital and/or Clinic) | **CLINIC NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DOCTOR/PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Receiving Party**- (Where do you want the information sent? Who may have the information?) | **CLINIC NAME:** Cascade Medical Care, LLC  **DOCTOR/PROVIDER**: Yvette Gaynor, FNP  **ADDRESS:** 1228 NW Canal Blvd  **CITY:** Redmond **STATE:** Oregon **ZIP:** 97756  **PHONE:** 541-923-3970  **FAX:** 541-699-4336  **EMAIL:** cascademedicalcare@gmail.com |
| **Information to be Released-** (What do you want sent or released? Check the appropriate box.) | **Routine Record Sets** (*indicate date(s) of service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)  □ Clinic (office visit, lab, radiology, medicines, immunizations)  □ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)  □ Billing Records □ Copies of Films/Images □ All records (Includes all types of records listed below. If you want to include images and billing records, check those boxes) □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Sensitive Health Information:**  **The following types of information will NOT be released unless you place your initials in the space provided**  **\_\_\_\_\_\_\_\_\_\_\_ HIV/AIDS test results**  **\_\_\_\_\_\_\_\_\_\_\_ Sexually Transmitted Disease (STD) Treatment records**  **\_\_\_\_\_\_\_\_\_\_\_ Alcohol/drug abuse treatment records**  **\_\_\_\_\_\_\_\_\_\_\_ Mental Health**  **OPTIONAL Limits - Disclose only records related to following:**  **Date(s) of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury or Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Purpose of Release**- (Why is it needed?) | □ Insurance □ Disability □ Personal □ Workers Comp  □ Continue of Care □ Legal Investigation □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
* Cascade Medical Care, LLC will not restrict my treatment if I choose not to sign this authorization.
* A photocopy/fax of this authorization will be treated in the same way as an original.
* Cascade Medical Care, LLC records may include records that it received from other organizations. If these records have been used by Cascade Medical Care, LLC and filed in the record Cascade Medical Care, LLC maintains about you, these records may be released with your Cascade Medical Care, LLC records.
* Cascade Medical Care, LLC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Cascade Medical Care, LLC from all liability resulting from a redisclosure by the recipient.
* Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

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Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document)