



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME _____ Date of birth ____/____/____

REQUESTING FROM _____
Name of physician or facility

Address

Phone _____ Fax _____

SEND TO Compassion Center
2055 W 12th Ave Eugene OR 97402
Voice: (541) 484-6558 Fax: (541) 484-0891

***Mail these records if 10 pages or more**

***Fax these records if ten pages or less**

I specifically authorize the release of the following records for the purpose of **Continuing Care**:

From period _____ to _____
Date Date

Documentation of diagnosis Physician/clinician chart notes

____ Other records (please specify): Radiology records _____

I also authorize the release of the following records. **Please initial (DO NOT CHECK) all that apply:**

___ HIV/AIDS-related records ___ Mental Health records ___ Drug/Alcohol-related records

You may revoke this authorization at any time by submitting a written request to:

Compassion Center, 2055 W. 12th Avenue Eugene OR 97402

The only exception is when action has already been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

My signature below acknowledges that I understand and accept this release of information.

Printed Name

Signature

Date