Arlington Family Healthcare
PO Box 314, 110 On The Mall
Arlington, Oregon 97812
Phone 541-454-2888 Fax: 541-454-2988

AUTHORIZATION AND CONSENT TO RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize Arlington Family Healthcare, Arlington, Oregon 97812 to Receive or Furnish the following medical, psychiatric, or psychological information from the records of:

Name of patient: ______________________ DOB: __________ SS# ______________

Address: ______________________________ Phone # ______________

FROM: ______________________ TO: Arlington Family Healthcare

Address: ______________________ Address: 110 On the Mall, PO Box 314

City, State, Zip ______________________ City, State, Zip: Arlington, OR 97812

Phone #: ______________________ Phone # 541-454-2888

Fax # ______________________ Fax #: 541-454-2988

INFORMATION TO BE RELEASED: ___History & Physical ___Pathology Reports ___ X-Ray Reports ___Progress Notes ___Medication Summary ___ Laboratory Reports ___Other

I realize that the information disclosed **may contain drug/alcohol** information that is protected by federal and state law including any testing results **documenting AIDS, ARC** and any other opportunistic diseases. I realize that the information **disclosed may contain mental health** information that is protected by federal and state law. I specifically consent to the disclosure of such information.

Reason for information to be released ______________________________

Signature of Patient/Guardian Date: Witness Signature Date:

______________________ ______________________

Medical Information Approved Sent:

Physician/FNP approved Signature ______________________ Date: ______________

This release expires 30 days from the date signed.

The AFHC has 30-60 days to release your records.

Revised 12/28/2022