

# Springfield Family Physicians Records Release Form - Incoming

Send Records to:  
Springfield Family Physicians  
2280 Marcola Road  
Springfield, OR 97477  
(541)747-4300 Fax: (541) 747-0655

Patient Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Other Names Used: \_\_\_\_\_

Phone Number (where you can be reached): \_\_\_\_\_

Please send the past 2 years of clinical notes and lab reports, and the past 5 years of xrays, diagnostic tests and operative reports. Additionally, I especially request records regarding: \_\_\_\_\_

I authorize the release of my medical records from:

Dr. Name: \_\_\_\_\_ Clinic/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

To Doctor: \_\_\_\_\_ Springfield Family Physicians

Request sent on \_\_\_\_\_ by \_\_\_\_\_ (SFP Staff)

## I understand that:

The purpose of this release is for on-going medical care.

The recipient of these records cannot transfer them to another party without consent from me (or authorized representative).

This authorization will expire in 60 days and can be revoked in writing at any time.

General medical records sometimes contain reference to drug use, alcohol use, rehabilitation treatment, psychiatric treatment, sexual abuse, and other sensitive issues. I agree to release these records.

I have read all of this release and any questions or concerns of mine have been answered.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Today's Date

I further authorize that all psychiatric, drug, alcohol, Acquired Immunodeficiency Syndrome (AIDS) or HIV/HTLV test results/records be released to the above. In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the PURPOSE of RELEASE of HIV/HTLV test results/records: \_\_\_\_\_

The HIV/HTLV test results may be released from \_\_\_\_\_ up to and including \_\_\_\_\_  
Today's Date Future Date

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Today's Date

**Please return a copy of this patient authorization with records**