NW Renal Clinic, Inc. - Good Samaritan
1130 NW 22nd Ave Suite 640 Portland, OR 97210
(503) 229-7976 Fax: (503) 274-4867

Patient Information

For :

Medical Record Release

Northwest Renal Clinic
1130 NW 22 Ave., Suite 640
Portland, OR 97210
Phone: _____ **Fax:** _____

Request and Authorization for Release of Protected Health Information

NAME _____
Last **First** **Initial**
ADDRESS _____
Street **City** **State**
DATE OF BIRTH _____ **AGE** _____ **PHONE #** _____

I hereby authorize and consent to disclosure of health records as stated below. Northwest Renal Clinic can **release and/or request** the following portions of medical records of the named patient, via fax machine, verbally or photocopy. A facsimile signature will be considered an original for this purpose.

Check one below:

_____ Entire medical record, **including** mental health, alcohol or drug abuse and/or HIV/AIDS information.

_____ Entire medical record, **with the exception of** information regarding mental health records, including alcohol or drug abuse and HIV/AIDS related treatment.

_____ The following specific portions of the medical record:

____ Dates _____ to _____.
____ Office/Clinic Notes
____ Operative Reports
____ Lab / Pathology Results
____ Radiology Reports
____ Immunization Records

INDIVIDUAL/INSTITUTION

RELEASING INFORMATION RECEIVING INFORMATION

Name _____ Name _____
Address _____ Address _____
_____ _____
_____ _____
Phone #: _____ Phone #: _____

PURPOSE OR NEED FOR THE INFORMATION?

_____ Personal Use
_____ Litigation / Legal
_____ Insurance
_____ Transfer of Care

It is understood that this request and authorization may be revoked by me (us) at any time in writing except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire 60 days from the date signed or upon

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the subsequently specified date, event, or condition:

_____

I (we) further agree that the Practice may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.

SIGNATURE _____ DATE_____
ADDRESS _____ PHONE _____

INDICATE PERSON SIGNING BY CHECKING APPROPRIATELY BELOW:

_____ Patient _____ Parent/Guardian of minor patient _____ Guardian of incompetent patient
Deceased patient's: _____ Personal Representative; if none, _____Spouse; if none _____ Any Child

It is understood that the foregoing is confidential information and will be considered as such. Furthermore, Northwest Renal Clinic is hereby released from any legal liability that might arise from release of such information. I understand that I may cancel this request at any time with a written notification, but that it will not affect any information released before notification cancellation.

_____ _____
Patient Name (Print) Last 4 of Social Security #

_____ _____
Patient Signature/Authorized Guardian Date

_____ _____
Witness Date