



# JUNCTION CITY MEDICAL CLINIC RECORDS RELEASE

355 W. Third Ave  
Junction City, OR 97448  
Phone: 541-998-6750 Fax: 541-998-1247

## PLEASE PRINT AND COMPLETE ALL SECTIONS

I authorize records to be released FROM: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Please release my records TO: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### PURPOSE OF RELEASE:

\_\_\_\_ Medical Care \_\_\_\_ Transfer of Care \_\_\_\_ Legal \_\_\_\_ Request of Individual \_\_\_\_ Other

### TYPE OF INFORMATION TO BE RELEASED:

\_\_\_\_ All Medical Records (Last two years unless otherwise requested)  
\_\_\_\_ Physician Notes  
\_\_\_\_ X-ray/Imaging Reports  
\_\_\_\_ Lab and/or Pathology Reports  
\_\_\_\_ Hospital Records/Consultations  
\_\_\_\_ Physical Therapy Records  
\_\_\_\_ Other \_\_\_\_\_

**\*\*\*\*\*MUST BE INITIALED TO BE INCLUDED\*\*\*\*\***  
\_\_\_\_ HIV/AIDS related records  
\_\_\_\_ Mental Health-counseling and/or treatment information.  
This includes depression, anxiety and stress related records.  
\_\_\_\_ Drug/alcohol diagnosis, treatment or referral information.  
Federal regulation 42CRF Part2 requires a description of how much and what kind of information is to be disclosed.  
If applicable, complete restricted box below.

### Restrictions-Initial and complete if applicable:

\_\_\_\_ This authorization is limited to the following time period: \_\_\_\_\_  
\_\_\_\_ This authorization is limited to the following treatment: \_\_\_\_\_

## PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

PO Box or Street

\_\_\_\_\_  
City, State, Zip Code

Phone Number (s): \_\_\_\_\_

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Junction City Medical Clinic or you. I understand that I can cancel my permission to disclose my information at any time in writing. This information may not be protected by Federal Privacy Regulation. Unless otherwise requested, the duration of this consent to Junction City Medical Clinic will be six months following the date of signature.

The purpose of this release is for ongoing medical care. Unless specifically requested, we will only release records generated by Junction City Medical Clinic.

The receipt of these records cannot transfer them to another party without consent from the patient or authorized representative, except for the purpose of treatment, payment or operations.

As a courtesy, we will forward your medical records to other physicians. Records requested for personal use will incur a \$25.00 fee for the first 10 pages and .25 cents per page thereafter.

\_\_\_\_\_  
Patient or Guardian/Parent  
(signature required by patient if fifteen years or older)

\_\_\_\_\_  
relationship to patient

\_\_\_\_\_  
date