

Medical Record Release and Transfer

Patient's Name:

Address _____

Phone _____ Email _____

Birthday _____ Social Security _____

Records From:

Address _____

Phone _____ Fax _____

Records To:

Kara Kassay MD

4309 Oakridge Road

Lake Oswego, OR 97035

Phone: 503-675-1137 Fax: 503-534-1137

(Please mail records > 20 pages)

The purpose of the use/disclosure is for _____

I authorize the release of the information specified below to the individual, organization or agency named on this request: **(initial all that apply)**

- _____ 1 All medical records generated by this facility
_____ 2 Only some portions of medical records maintained at this facility (specify below)

I specifically authorize the release of information regarding the following condition/s **(please initial)**

_____ Drug Abuse if any _____ Psychological or Psychiatric condition if any
_____ Substance abuse if any _____ AIDS/HIV if any

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time. A copy of this authorization may be utilized with the same effectiveness as an original.

Charges may be incurred for copying costs. The rate is \$30.00 for the first ten pages, \$0.50 per 11-49 and \$0.25 per page thereafter. Fees are determined by the number of pages allowed by state law. There is no charge for records transferred between healthcare providers.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____