Medical Record Release and Transfer

Patient's Name: _____

Address _____

Phone _____ Email _____

Birthday _____

Records From: _____

Address _____

Phone _____ Fax _____

Records To:

Kara Kassay MD

12511 SW 68th Ave
Portland, OR 97223
Phone: 503-675-1137 Fax: 971-350-1552
(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
_____ Substance abuse if any
_____ Psychological or Psychiatric condition 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 _____