

Pendleton Police Department
109 SW Court Avenue
Pendleton, OR 97801
Phone: 541-276-4411
Fax: 541-276-9108

MEDICAL RELEASE FORM AUTHORIZATION AND CONSENT

The undersigned hereby authorizes and consents to the release and disclosure of Medical Record Information.

1. I hereby authorize _____ , _____

_____, to release the following
health record information.

2. Name and address of the Institution or Person to whom disclosure is to be made:

3. Patient information: _____

4. Purpose for which disclosure is to be made: _____

5. What information is to be disclosed (initial one or more):

_____ Discharge Summary	_____ Radiology Reports
_____ History & Physical	_____ Laboratory Reports
_____ Operative Reports	_____ Emergency Room Record: (Date)
_____ Pathology Reports	_____ Other (Specify)
_____ Physician's Orders	_____
_____ Progress Notes	_____

6. THIS CONSENT EXPIRES: WITHIN 60 DAYS OF DATE OF THIS REQUEST, UNLESS REVOKED EARLIER.

7. DATE OF CONSENT: _____ X _____
SIGNATURE OF PATIENT

OTHER PERSON AUTHORIZED TO SIGN FOR PATIENT

RELATIONSHIP