

REQUEST FOR DISCLOSURE OF MEDICAL RECORDS

This request must be written, dated and signed by the patient or by a person authorized by law to make such request.

To facilitate my legal representation and pursuant to 45 CFR 164.502(a)(1)(i), I request to RELEASE A COPY OF MY MEDICAL INFORMATION, and to COMMUNICATE MY MEDICAL INFORMATION ORALLY, to my attorneys:

Wilson Law Office
101 E. Broadway, Suite 220
Eugene, OR 97401

By initialing the spaces below, I specifically consent to the release of the following medical records, if such records exist:

- All hospital records (including nursing records and progress notes)
Transcribed hospital reports
Medical records needed for continuity of care
Most recent five year history
Laboratory reports
Pathology reports
Diagnostic imaging reports
Other
Clinician office chart notes
Dental records
Physical therapy records
Emergency and urgency care records.
Billing statements
HIV/AIDS-related records

*Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

*If you intend to have your "entire medical record" sent to the recipient and would like to include your "HIV/AIDS-related records", you will need to initial both lines.

- **Mental health information
**Genetic testing information (Must be initialed to be included in other documents)

**Drug/alcohol diagnosis, treatment, or referral information:

This consent is limited to the following treatment:

This consent is limited to the following time period:

**Federal Regulation, 42 CFR 2.31 requires a description of how much and what kind of information is to be disclosed.

This consent may be revoked at any time. The only exception is when action has been taken in reliance on the consent. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Photocopies of this consent shall have the same validity as the original. ALL PRIOR CONSENTS ARE HEREBY CANCELED.

Date

Name (Please Print)

Social Security No.

Name (Please Sign)