

**FORM
B**

Legacy Employee Health
 1919 NW Lovejoy Avenue
 Portland, Oregon 97209
 Phone: (503) 415-5306
 Fax: (503) 415-5192



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Client Name	Date of Birth	Social Security Number
Client Address		Employee Number (optional)

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

1. This authorization may include disclosure of information relating to Alcohol and drug abuse, mental health treatment, and confidential HIV related information unless I specifically indicate for it to not be sent in the space provided below.

2. I understand that this authorization expires 60 days from today and will need to be renewed after that date. I have the right to revoke this authorization in writing before then. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

3. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

4. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

5. This authorization does not authorize you to discuss my health information or medical care with anyone other than the individual or agency specified.

6. I have the right to a copy of this release and of applicable privacy policies.

Records may be released by:	Fax, Phone, or Email:
Records should be sent to:	Fax, Email, or Address:
Records requested: <input type="checkbox"/> All Vaccination Records <input type="checkbox"/> All lab results pertaining to Employment <input type="checkbox"/> Other information to be released:	Reason for release: <input type="checkbox"/> Client request <input type="checkbox"/> Provider request <input type="checkbox"/> Employment/School

This form has been completed and my questions about this form have been answered.

Signature of client or authorized representative

Date