Legacy Employee Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM A DESIGNATED REPRESENTATIVE

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***
Legacy Employee Health 2145 NW Overton St. Portland, OR 97210	***P)***: 503-415-5820 ***(F)***: 503-415-5192 ***(E)***: Employeehealth@lhs.org
Records should be sent to:	***Fax, Email, or Address***:
Records requested:	***Reason for release:***
☐ All Vaccination Records ☐ All lab results pertaining to Employment ☐ Other information to be released:	☐ Client request ☐ Provider request ☐ Employment/School

All items on this form have been completed and my questions about this form have been answered.

Signature of client or authorized representative Date

LEGACY HEALTH