DESCHUTES
FAMILY CARE

**Medical Records Release**

**Name** _____ **Date of birth**_____

**Address** _____
Street City State ZIP

**Phone** _____ **Parent/Guardian** _____

**Please transfer my medical records as follows:**

From: _____
_____
_____
_____
_____

To: **Deschutes Family Care**
1345 NW Wall St, ste 302
Bend, OR 97703
Phone: (541) 323-3960
**Fax: (541) 323-3961**

**Records to be released**:
__ All medical records
__ Date range _____ To _____
__ Labs & Imaging (diagnostics, xray, CT, MRI, ultrasound, etc.)
__ Specialist consults/referrals
__ Reproductive health (birth control, pregnancy, abortion, miscarriage, etc.)
__ Other _____
_____

*I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. _____ **Initial to consent to additional release***

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 365 days from date below.

_____ _____
Signature Date

_____
Witness