Virginia Garcia Memorial
HEALTH CENTER

Release of Information (ROI)

P.O. Box 568 Cornelius, OR 97113
(P) 503-359-8501 (F) 503-357-4371

Patient Label Here

Patient Name: _____

Aliases, Nicknames, or Other Names: _____

Date of Birth: _____

Please get health information from / give health information to:

_____
Name & Title of Provider / Organization Name/ Individual

_____
Street Address (or specified fax number)

_____
City / State / Zip (This information must be provided)

REQUIRED: Check only one box

I give permission to VGMHC to:

- ❑ **Obtain (get) information**
- ❑ **Release (give) information**
- ❑ **Exchange (share) information**

For the purpose of: ❑ Patient Care ❑ Self: Personal Records ❑ Other_____

Type of information:

❑ Most recent 2 years of records ❑ All records ❑ Most recent office visit note
❑ History & Physical Exams ❑ Consultations ❑ Laboratory reports ❑ X-ray/imaging reports
❑ Pathology reports ❑ Immunizations ❑ Problem List
❑ Other (specify): _____

Records for the following dates or treatment: _____

If the records include any of the following types of special information below, laws relating to the use and disclosure of this information may apply. **I understand and agree that this information will be given if I place my initials in the space next to the type of information.**

_____* HIV / AIDS related information and / or records
_____* Mental Health Information
_____* Genetic Testing information
_____* Drug / Alcohol diagnosis, treatment, or referral information

Duration: This authorization shall begin immediately and remain in effect until (date):_____ **OR** until the patient is no longer a VGMHC patient.

RESTRICTIONS: If we received records from other clinics, it may become part of your chart and may be re-released and may no longer be protected by privacy laws or regulations.

RIGHTS: You do not have to sign this form and you can still get treatment if you don't sign it (unless the services are solely for the purpose of giving health information to someone else and your permission is necessary to release that information). You may view or copy any information to be given related to this ROI form as allowed by VGMHC policy.VGMHC has up to 30 days to process your records request.

CANCELLING THIS FORM: You may cancel this ROI in writing at any time. Any records already sent or received made with your permission cannot be undone but we will honor the cancellation going forward. To cancel this form, please send a written statement to the clinic manager and state you are revoking this authorization or ask for the ***Revocation of Authorization*** form.

I have read this authorization, or it has been read to me, and I understand it. *He leido esta autorizacion, o me la han leido y la he entendido.*

Signed: _____ Date: _____
(Patient or personal representative)

Description of personal representative's authority *(relationship):*_____

Interpreted by (if applicable): _____

STAFF ONLY: I have verified
❑ Form is complete ❑ Identification of Requestor ❑ Relationship (if not patient)
Name _____ Date_____

Position_____