Umpqua Orthopedics

As per OAR 847-012-000
Medical records requests will be completed within 30 days from the date the signed request is received in our office.

Medical Records Release for Umpqua Orthopedics Records

Patient Name: _____DOB: _____ SSN: XXX-XX-_____

Email: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____ Fax Number: _____

Where are we sending the records?

Name: _____

Email: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____ Fax Number: _____

Please check the categories listed that you want released in this request:

_____ All Records

_____ All Records (within last 6 months)

_____ Office/Clinic Notes

_____ Operative/Procedure Notes

_____ Lab/Pathology Results

_____ Radiology Reports

_____ Secure Email containing X-ray taken in our office

____ Other _____

If you do not want certain portions of your medical records released, please check the categories listed below that you would like EXCLUDED:

_____ Substance Abuse, if any _____ AIDS/HIV/STDs, if any _____ Psychological/Psychiatric Conditions, if any

Purpose of Disclosure

_____ Personal Use _____Litigation/Legal _____Insurance _____Transfer of Care (Last two years sent to a physician)

** Per OAR 847-021-0000, you may be charged a reasonable fee for reproducing medical records.
Fees are non-refundable once services are rendered. Payment is due in advance.

How would you like the records sent? **Delivery Method**

Email: _____ Fax: _____

Mail to (postage fee may apply): _____

I hereby authorize Umpqua Orthopedics and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on the request and will not longer be protected by federal regulations.

Patient Signature: _____ Date: _____

Relationship to patient: _____