Umpqua Orthopedics

Medical Records Release for Umpqua Orthopedics to obtain records from another Physician or Facility

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

Email: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____ Fax Number: _____

Where / Who are we requesting your records from?

Name: _____

Email: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____ Fax Number: _____

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

_____ All Records

_____ All Records (within last 6 months)

_____ Office/Clinic Notes

_____ Operative/Procedure Notes

_____ Other _____

_____ Lab/Pathology Results

_____ Radiology Reports

_____ Imaging CD of any imaging or push to Mercy Medical Center via Power Share

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)

Please send records to:
Umpqua Orthopedics
277 NW Medical Loop
Roseburg, Oregon 97471-1644
Phone: 541-677-2131
Fax: 541-677-2136
Email: info@umpquaortho.com

I hereby authorize the facility/physician listed above and its affiliates to release or disclose to Umpqua Orthopedics, 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: _____