Virginia Garcia Memorial
HEALTH CENTER

Release of Information (ROI)

P.O. Box 6149 Aloha, OR 97007
(P) 503-359-8501 (F) 503-357-4371

Please do not fax more than 20 pages

Place Patient Label Here

Patient Name

Other names used (Alias) | Date of Birth | Email Address

For the health information below I authorize Virginia Garcia to: (✓ ONLY ONE BOX)
☐ Get information ☐ Give information
☐ Get and give information

To and From:

Name of Provider / Facility / Individual

Mailing address

City, State, Zip Code

Phone | Fax

I authorize sharing of:
☐ Verbal information with the provider/facility/individual above
☐ Past records ☐ Future Records

For this purpose:
☐ Coordination of care ☐ For my own use ☐ Insurance/Legal
☐ Other (Explain):

And time period:
☐ As often as needed ☐ For this one time only

Requested information includes:
(check the boxes that apply)

Progress Notes: ☐ Last 3 visits OR ☐ Dates From: _____ to _____
☐ Problem List reports ☐ Dental Care ☐ X-ray/imaging reports
☐ Immunizations ☐ Laboratory/pathology reports ☐ Relevant Family Planning
☐ Medication List and Prescription Monitoring ☐ Consultations
☐ **All health records** (This form excludes the release following health type of records unless the box(es) are checked below)
- ☐ HIV/AIDS/STD: related testing, results, referrals, treatment
- ☐ Genetic Testing information
- ☐ Mental Health: evaluation, diagnosis, treatment, progress to date, medication monitoring, psychological evaluation records
- ☐ Drug/Alcohol: evaluation, diagnosis, treatment, progress to date, medication monitoring
- ☐ Other (Explain): _____

I UNDERSTAND THAT:

RESTRICTIONS: If we already have records from other clinics, it may become part of your chart and may be re-released and not be protected by privacy laws or regulations, except for Alcohol and Drug treatment records we received from a treatment facility or program.

RIGHTS: You do not have to sign this form and you can still get treatment or eligibility for benefits (unless the services are solely for the purpose of giving health information to someone else and your permission is necessary to do that). You may view or copy any information given related to this ROI as allowed by VGMHC policy. VGMHC has 30 days to process your records request. *If have not received your records, please contact the Medical Records Department at (503) 359-8501*

CANCELLING THIS FORM: You may cancel this ROI in writing at any time. Any records already sent or received with your permission cannot be undone but we will honor the cancellation going forward. To cancel this form, please send a written statement to PO Box 6149, Aloha, OR 97007 and state you are revoking this authorization or ask any employee for the ***Revocation of Authorization*** form.

The information released in agreement with this authorization may be protected by 45 CFR Part 160 and Subparts A and E or Part 164 and applicable state law (ORS 179.505, 192.525).

I have read this authorization, or it has been read to me. I understand that this authorization begins immediately and remains in effect until my care ends with Virginia Garcia, or unless I specify a different date or event here: _____
Date/Event

_____ _____
Signature or Patient or Legal Representative/Guardian *Date Signed*

_____
Printed Name of Patient/Legal Representative/Guardian

_____
Relationship to patient (If not the patient)

VGMHC STAFF ONLY

Name of Provider or Clinician requesting records: _____

☐ Form is complete
☐ Identification of Requestor Verified
☐ Relationship Verified ***(if not patient)***

_____ _____ _____
Name of Employee Receiving ROI Position Clinic

Comments: _____