

allergy associates research center  
6327 SE Milwaukie Avenue, 2<sup>nd</sup> Floor  
Portland OR 97202

**(503)238-6233 \* FAX (503)231-7668**

**Authorization to Release Medical Information**

Patient Name _____	Date of Birth _____
Daytime Phone _____	Evening Phone _____
<b>I AUTHORIZE INFORMATION RELEASED FROM:</b>	<b>PLEASE SEND MY RECORDS TO:</b>
_____	<b>Allergy Associates Research Center</b>
Name of Facility <input type="checkbox"/> Kaiser <input type="checkbox"/> Legacy <input type="checkbox"/> OHSU <input type="checkbox"/> VA <input type="checkbox"/> Adventist	Attn: _____
Name of Physician _____	<b>6327 SE Milwaukie Avenue, 2<sup>nd</sup> Floor</b> <b>Portland OR 97202</b> <b>503-238-6233 (ph) 503-231-7668 (fax)</b>
Phone Number of Facility _____	
<b><i>The purpose for which these medical records will be used is for treatment in a research study.</i></b>	

Would you kindly furnish them with the following information from my records?

- \_\_\_\_\_ All Medical Records
- \_\_\_\_\_ X-Ray Results, including dates
- \_\_\_\_\_ Lab Work
- \_\_\_\_\_ Operative Reports
- \_\_\_\_\_ Other: \_\_\_\_\_

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the information.

- \_\_\_\_\_ HIV/AIDS information
- \_\_\_\_\_ Mental Health information
- \_\_\_\_\_ Genetic Testing information
- \_\_\_\_\_ Drug/Alcohol diagnosis, treatment, or referral information

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for getting on a research study.

**X**

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<b>Signature of patient or legally responsible Person</b>	<b>Relationship to Patient</b>	<b>Date</b>
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***This authorization is valid for 1 year and may be revoked by the patient (orally and in writing) at any time prior to 1 year.***