



SOUTHERN OREGON INTERNAL MEDICINE  
 2900 Doctors Park Drive  
 Medford, OR 97504

**Authorization to Release Medical Information**

Patient: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I consent to the release of Medication Information (records):

**To:** (Physician, Clinic, or Person)

**From:** (Physician, Clinic, or Person)

Name: John B Groves, DO  
 Address: 2900 Doctors Park Dr. Suite 200  
 City/State/Zip: Medford, OR 97504  
 Phone: 541-282-2200  
 Fax: 541-282-2260

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**\*\*PLEASE SEND THE RECORD ON CD OR THUMB DRIVE WHEN POSSIBLE; DO NOT FAX MORE THAN 25 PAGES\*\***

**Information to be released:** (initial each line that applies)

- \_\_\_\_\_ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, Diagnostic & Laboratory Reports. From Date: \_\_\_\_\_ To Date: \_\_\_\_\_
- \_\_\_\_\_ Diagnostic reports only. Date(s): \_\_\_\_\_
- \_\_\_\_\_ Laboratory and Pathology reports only. Date(s): \_\_\_\_\_
- \_\_\_\_\_ Other tests or studies (list type of test/study and date performed: \_\_\_\_\_)
- \_\_\_\_\_ Other (specify): \_\_\_\_\_

**In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. \*(Initial if release is authorized)**

- \_\_\_\_\_ Drug and alcohol abuse
- \_\_\_\_\_ Information related to diagnosis/treatment of HIV.

**Please note that a separate release of behavioral health information is required.**

**Purpose of Disclosure:**

\_\_\_\_\_  
 \_\_\_\_\_

**\*\*A charge of \$25.00 for the first ten (10) pages and .28 cents for each page over ten (10) may apply.**

This authorization is valid for six months after the date of signature. If the undersigned provides written notice of revocation, it may be revoked at any time (but not retroactively to a release of information made in good faith).

\_\_\_\_\_  
 Signature of patient or legally authorized representative

\_\_\_\_\_  
 Date