

**AUTHORIZATION TO  
RELEASE MEDICAL INFORMATION**

Please obtain medical records and information pertaining to medical history, mental or physical condition services rendered, or treatment of:

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Please OBTAIN Information FROM the following:

Please SEND my medical information TO:

\_\_\_\_\_  
Name & Title of Provider/Organization

**HIDENAO KIMURA, M.D.**  
\_\_\_\_\_  
Name & Title of Provider/Organization

\_\_\_\_\_  
Street Address

**16463 Boones Ferry Road , bldg. 300**  
\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

**Lake Oswego, OR 97035**  
\_\_\_\_\_  
City/State/Zip

**For the Purpose of:**  Patient Care  Insurance Claim  Self  Other (List) \_\_\_\_\_

**List specific dates of records to be released:** 10 years

**Duration:** This authorization shall begin immediately and remain in effect until (date): 1 year

**I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:**

**ALL RECORDS**

**The following (marked \*) must be initialed by the requestor to be included in the use and/or disclosure of other health information:**

\_\_\_\_\_ \*HIV / AIDS related information and/or records \_\_\_\_\_ \*Mental Health Information  
\_\_\_\_\_ \* Genetic Testing information \_\_\_\_\_ \*\*Drug/alcohol diagnostics, treatment, or referral information

\*\*Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.

**Restrictions:** I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

**Rights:** I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

\_\_\_\_\_  
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_