Friendsview
RETIREMENT COMMUNITY

RELEASE OF MEDICAL RECORDS

Medical records are required prior to applicant's move to Friendsview Retirement Community

_____
(Name of Friendsview Applicant)

I am applying for admission into Friendsview Retirement Community and authorize my primary care physician _____ to release copies of my
(Physician's Name)
medical records. Because these records are required prior to my move-in, I ask that they be sent at your earliest convenience to:

Friendsview Retirement Community
Attn: Danika Porter, RN
1301 East Fulton Street
Newberg, Oregon 97132
Phone: 503-538-3144
Fax: 503-538-6371

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Transcribed hospital reports from the last 12 months
_____ The last three-year records of my history/physical exams
_____ Most recent laboratory reports
_____ Clinician office chart notes from the last 12 months
_____ HIV/AIDS related records
_____ Mental health information
_____Drug/alcohol diagnosis, treatment or referral information.

This authorization may be revoked at any time, but that revocation will not affect any information already released. Unless revoked earlier, this consent will expire 180 days from the date of signing. The information will be used on my behalf for evaluating my medical needs in a continuing care setting.

Signature of applicant: _____

Today's date: _____

Date of birth:_____