Washington County 911
17911 NW Evergreen Pkwy
Beaverton, OR 97006

Audio Request Contact Info
Phone: 503-690-4911
Fax: 503-531-9320
Email: audiorequest@wccca.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This Authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize Washington County Consolidated Communications Agency ("WCCCA") to release a copy of the medical record obtained and/or recorded by their employees to the person identified below. I specifically authorize the release of information pertaining to drug or alcohol abuse, psychological or psychiatric conditions, and/or communicable disease information, if such are a part of the medical record. I understand this record may be voluminous and agree to pay all reasonable charges associated with providing this record. I understand WCCCA may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that information used of disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy provided by law.

Patient Name: (print) _____

Patient Date of Birth: _____ / _____ / _____ Incident No. _____

Purpose of Request: ☐ At the request of the individual.
☐ Other _____

Identification:
☐ Driver's License ☐ SS Card ☐ Student ID ☐ Passport ☐ Personal Representative
☐ Other_____

* * * * * * * * * * * * * *

Please release to: (print) _____

Street/PO Box: _____

City/State/Zip: _____

Phone: _____

This Authorization may be revoked at any time. To revoke this Authorization, I understand that I must do so by written request to the Washington County Consolidated Communications Agency Records Custodian at the address below. The only exception is when action has been taken in reliance on the Authorization. Unless revoked earlier, this consent will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

_____ _____
Date Signature of Patient or Other Person Authorized to Sign for Patient

_____ _____
Relationship to Patient Printed Name