

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

I hereby authorize _____
(Fill in name of Doctor's Office/Individual/Facility)

(Fill in Address City, State, Zip)

Fax Number: _____ Phone Number: _____

To release a copy of medical information to:

(Southern Oregon Alternative Medicine)
152 Main Street Springfield, OR 97504
Office: (541) 844-1708 Fax: (541) 515-6957

The information will be used on my behalf for the following purpose(s): Alternative Therapy.

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

Pages documenting the diagnosis of _____

___ All hospital records (incl. Nursing records and progress notes)

___ Transcribed Hospital Reports

___ Physical therapy records

___ Most recent TWO yea history

___ Emergency and urgency care records

___ Entire medical Record (all information)

___ Genetic testing information

___ Pathology reports

___ Dental records

___ MRI/ X-ray reports

___ Laboratory reports

___ AIDS or HIV information

___ Drug and Alcohol Information

___ Other _____

If we are requesting this Authorization from you for our own use and disclosure, or to allow another health care provider or health plan to disclose information to us:

1. We cannot condition our provision or services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy if the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of the signed authorization

You have the right to revoke the Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

- I have reviewed and I understand the Authorization. I also understand that the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

***Signature of Patient: _____

***Date: _____

OFFICE USE ONLY

- Date of Faxed:
- Date of Appt:
- Chart Notes Received: