AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **DOB:**_____

Patient Phone number: _____

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

_____
(Fill in address)

_____
(City, State and Zip Code)

Fax Number:_____ **Phone Number:**_____

To release a copy of medical information to:

_____
(Southern Oregon Alternative Medicine)
1607 Williams Hwy #5 Grants Pass, OR 97527
Ph: 541-479-2251 Fax: 541-955-2928

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 records, if such records exist:

___Pages documenting the diagnosis of_____

___ **LAST VISIT ONLY**
___All hospital records (incl. Nursing records and progress notes)
___Transcribed hospital reports
____Physical therapy records
___ **Most recent TWO-year 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 this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.**

Signature of Client/Patient:_____

Date: _____

OFFICE USE ONLY
- Date Faxed:
- Date of Appt:
- Chart Notes Received:
- NEW OR RENEW_____