

CENTER for  
NATURAL MEDICINE, INC  
1330 SE 39<sup>th</sup> Avenue, Portland, Oregon 97214  
tel. 503-232-1100 fax 503-232-7751 www.cnm-inc.com

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

*This document must be written, dated, and signed by the patient or by a person legally authorized to do so.*

Patient Name (Last, First, Middle Initial) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Medical Record Number (if applicable) \_\_\_\_\_

I authorize (name of provider, address, and telephone/fax number): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release a copy of the medical information/records specified below to (check a box):

\_\_\_\_\_  DR. \_\_\_\_\_ / CNM \_\_\_\_\_  
\_\_\_\_\_ OR 1330 SE 39<sup>th</sup> Ave, Portland, OR 97214  
\_\_\_\_\_ Fax: (503) 232-7751

The information will be used on my behalf for continuity of care and/or the following purpose(s):  
\_\_\_\_\_

By **INITIALING** the spaces below, I specifically authorize the release of the following medical records and personal health information, if such records exist:

- |   |   |
|---|---|
| <input type="checkbox"/> All hospital records (including nursing records and progress notes)  | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> Transcribed Hospital Reports   | <input type="checkbox"/> Dental Records               |
| <input type="checkbox"/> Records needed for continuity of care  | <input type="checkbox"/> Laboratory Reports           |
| <input type="checkbox"/> Most recent five year history  | <input type="checkbox"/> Pathology Reports            |
| <input type="checkbox"/> Emergency and urgent care records  | <input type="checkbox"/> Billing Statement            |
| <input type="checkbox"/> Diagnostic imaging reports   |   |
| <input type="checkbox"/> Other: _____   |   |
| <input type="checkbox"/> Please send the entire medical record. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record. |   |

\*The following items must be **INITIALED** to be included in other released documents:

- HIV/AIDS related records
- Mental health information
- Genetic testing information
- Drug/Alcohol diagnosis, treatment or referral information : description required: \_\_\_\_\_

- This authorization is limited to records regarding the following treatment: \_\_\_\_\_
- This authorization is limited to records from the following time period: \_\_\_\_\_
- This authorization is limited to worker's compensation claim for injuries dated: \_\_\_\_\_

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

\_\_\_\_\_  
Date Signature of Patient or Legally Authorized Party Relationship to Patient