CENTER for
NATURAL MEDICINE, INC
1330 SE 39th 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 39th 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:

___ All hospital records (including nursing records and progress notes)
___ Transcribed Hospital Reports
___ Records needed for continuity of care
___ Most recent five year history
___ Emergency and urgent care records
___ Diagnostic imaging reports
___ Other: _____
___ 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.

___ Clinician office chart notes
___ Dental Records
___ Laboratory Reports
___ Pathology Reports
___ Billing Statement

***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**