Center for Natural Medicine
1330 SE Cesar E Chavez Blvd
Portland, OR 97214
tel. 503-232-1100 | fax 503-232-7751

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 _____ Date of Birth ____/____/_____

I authorize the clinic/facility/provider named below to release a copy of the specified medical information/records to CNM.

Clinic to receive information:
The Center for Natural Medicine
1330 SE Cesar E Chavez Blvd
Portland, OR 97214

Clinic/facility/provider to release information:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

☐ ***The information requested will be used on my behalf for facilitating treatment and for continuity of care.***

Patient reason, if different than above: _____

By marking the boxes below, I specifically authorize the release of the following personal health information:

Date range for records requested, if applicable: *From:*_____to_____

- ☐ All existing medical records held by the above-named entity
- ☐ All clinician office chart notes
- ☐ Most recent 5-year history
- ☐ Most recent 1-year history
- ☐ All diagnostic imaging reports
- ☐ All laboratory reports
- ☐ All pathology reports
- ☐ All Hospital records
- ☐ Emergency/urgent care records
- ☐ Dental records
- ☐ Billing statements
- ☐ All patient forms and questionnaires
- ☐ All administrative records
- ☐ Other: _____

Additional laws apply relating to the following information which require specific permission for disclosure, and I give that authorization by my initials below regarding:

____HIV/AIDS ____Mental Health ____Genetic testing ____Drug/Alcohol testing, Diagnosis, Treatment

I understand that the information pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law when it is re-disclosed. I also understand that signing this release is voluntary and if I were to refuse, it would not adversely affect my ability to receive healthcare services unless the service is for the sole purpose of providing information and requires written release.

This authorization is in effect through ___/___/_____ or until I revoke this consent. I understand that I may revoke or terminate this authorization by submitting a request in writing to The Center for Natural Medicine.

I have read and understood this authorization.

___/___/_____ _____ _____

Date Signature of patient/authorized party Relationship to patient

Print name if other than patient: _____