CENTER for NATURAL MEDICINE
1330 SE Cesar E Chavez Blvd (39th Ave)
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 (name of provider & contact info): _____

_____

_____

***To release a copy of the medical information/records specified below to*:**

☐ _____
_____
_____
_____

OR

☐ **The Center for Natural Medicine**
DR _____
1330 SE Cesar E Chavez Blvd (39th)
PDX OR 97214 Fax 503-232-7751

The information will be used on my behalf for facilitating treatment and/or the following purpose(s):

_____

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

____ All hospital records
___ Most recent 5-year history
___ Emergency/urgent care records
___ Diagnostic imaging reports
___ Billing statements
___ Other: _____

____ Clinician office chart notes
_____ Dental records
_____ Laboratory reports
_____ Pathology reports

Additional laws apply relating to the following information, requiring specific permission for disclosure and I give that specific authorization only 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 __/__/__ until I cancel this consent. I understand that I may revoke or terminate this authorization by submitting a request in writing to Center for Natural Medicine.

I have read and understand this authorization.

_____ _____ _____

Date **Signature of patient or legally authorized party** **Relationship to patient**