

Request and Authorization to Release Medical Information

I hereby authorize:

_____ (doctor) of

_____ (clinic name)

_____ (address)

_____ (city, state, zip)

_____ (tel and fax)

To send my medical records to:

Petra Caruso, ND
Woodstock Natural Health Clinic
4940 SE Woodstock Blvd.
Portland, OR 97206
Phone: 503-771-0615
Fax: 503-771-1660

Patient Information

_____ (name)

_____ (SSN) _____ (DOB)

_____ (Ph) _____ (address)

_____ (City, state, zip)

By indicating below, I authorize the release of the following specific confidential information:

- Health Records (specify) _____
- Lab Results
- XRay Results
- Other _____

I hereby consent to release the above information including alcohol, drug abuse, mental health records and HIV testing obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent except in a medical emergency. I further understand that this authorization is valid for six months from the date of signing unless revoked in writing earlier. The only exception is when the action has already occurred as instructed in the consent.

_____ **Signature** _____ **Date**

_____ **Relationship to patient**