

*Naturopathic Family Medicine*

6501 SE King Road

Milwaukie, OR 97222

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**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

*This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the hospital/health care provider stated below to release a copy of medical information for the above named patient to Dr. Meredith McClanen.

Name of Hospital/Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

The information will be used on my behalf for the following purpose(s):  
\_\_\_\_\_

By **INITIALING** the spaces below, I specifically authorize the release of the following medical records\*, if such records exist:

- \_\_\_ All hospital records (including nursing records and progress notes)
  - \_\_\_ Transcribed hospital reports
  - \_\_\_ Medical 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 (all information) to the above named recipient.
- \_\_\_ Clinician office chart notes
  - \_\_\_ Dental records
  - \_\_\_ Laboratory reports
  - \_\_\_ Pathology reports
  - \_\_\_ Billing statements

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

- \_\_\_ **\*HIV/AIDS related records**
- \_\_\_ **\*Mental health information**
- \_\_\_ **\*Genetic testing information**
- \_\_\_ **\*Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:**  
\_\_\_\_\_

- \_\_\_ 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 a worker's compensation claim for injuries of \_\_\_\_\_ (date).

*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)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of person authorized by law)