



Patricia J Meyer, ND Lee Dennis, ND 12616 SE Stark Street Portland, OR 97233 (503) 408-0790

### **AUTHORIZATION FOR RELEASE OF RECORDS**

**I request records from the following Dr. and/or clinic:**

Dr. Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<b>Please release the following records (initial):</b>	<b>Please INCLUDE the following (initial):</b>
_____ All records	_____ Mental Health Records
_____ Chart notes	_____ Communicable diseases includes (HIV/AIDS)
_____ Diagnostic imaging reports	_____ Alcohol/drug abuse treatment
_____ Lab results	_____ Genetic testing
_____ Other _____	_____ Other _____

☐ For all dates of service      **OR**      ☐ For the following dates only: \_\_\_\_\_

**Requested for the following patient:**

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

**I request copies of the above records to be released to:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultations, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect for one year from the date above, at which time this authorization expires.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer had legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**I give permission for the above records to be released.**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_