# Patient's Authorization to Release Medical Records

PATIENT INFORMATION

Name: _____

Birthdate: _____

Daytime Phone Number: _____

HOLDER OF ALL MEDICAL RECORDS

Name of Facility / Physician: Peterson Clinic
Street: 1002 W. Elm Ave./P.O. Box 211
City: Hermiston, State: OR Zip: 97838

Phone: 541-567-6277 Fax: 541-567-9055

From dates of service _____to_____

INFORMATION TO BE RELEASED
A copy of complete health records, including but not limited to: chart notes, clinical profile, demographics, diagnosis codes, past medical history, OTC medications (supplements), lab and imaging reports/results (MRI, CT, US, etc.) from all providers

- Dr. Kristopher Peterson
- Dr. Trent Teegarden
- Dr. Kenneth Peterson
- Dr. Kenzie Maloy.

I,_____ request the immediate release of any email addresses associated with me in the Elation Passport patient portal.
_____ initial

INFORMATION IS TO BE RELEASED AND SENT TO: Mailing Address
**Dr. Kenzie Maloy DC, LLC**
**Pinnacle Natural Health Center**
**1000 S. Hwy 395, PMB A505**
**Hermiston, Oregon 97838**
**Phone: 541-371-3700**
**Fax: 541-515-7022**

PATIENT CONSENT AND AUTHORIZATION TO RELEASE MEDICAL RECORDS
This authorization is valid for ninety (90) days from the date signed. I understand this consent can be revoked by me at any time before disclosure has occurred.
Unless specifically excluded, this authorization includes release of specially protected records-such as referral to, diagnosis of, and/or treatment for substance abuse, mental health conditions, and sexually transmitted diseases such as HIV.
I understand that records of my healthcare are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for or allowed by these regulations.

Patient/Guardian Authorizing Signature: _____ Date: _____

MINOR'S CONSENT
This applies to persons aged 13 to 18 for records pertaining to substance abuse and/or mental health records, and to persons aged 14 to 18 for records pertaining to sexually transmitted diseases, including HIV.

Minor's Signature: _____ Date: _____