Patient's Authorization to Release Medical Records

PATIENT INFORMATION

Name: _____

Birthdate: _____

Daytime Phone Number: _____

HOLDER OF ALL MEDICAL RECORDS

Name of Facility / Physician: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

[Optional] Approximate Date of Beginning: _____

Present Date : _____

INFORMATION TO BE RELEASED
Copy of complete health records including chart notes
Lab and imaging reports/results (MRI, CT, US, etc.)

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: _____