

## Authorization to Release Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

Patient: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_\_

Please **release** my medical information **from**:

**Prema Health**  
2305 SE 50<sup>th</sup> Ave, Suite 200  
Portland, OR 97215  
Phone: 971-407-3428  
Fax: 971-703-4735

Please **send** my medical information **to**:

**Wildflower Natural Medicine**  
1516 SE 43<sup>rd</sup> Avenue, Suite 4  
Portland, OR 97215  
Phone: 503-974-4813  
Fax: 503-662-7574

By checking the spaces below, I authorize the above physician/clinic to release written records pertaining to the following information going back one year. I also authorize the above physician/clinic to provide the following information via telephone consultation:

Medical records needed for continuity of care     Diagnostic imaging reports  
 Pathology reports     Laboratory reports  
 Other: **ENTIRE RECORD**

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Parent/Guardian if applicable

\_\_\_\_\_  
Signature of

I understand that certain information in these records can not be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the above physician/clinic to release the following confidential information. I also authorize the above physician/clinic to provide the following information via telephone consultation.

HIV/AIDS test results and related information, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of tested individual.

\_\_\_\_\_  
Patient Signature

Drug/Alcohol diagnosis, treatment or referral information, mental health treatment information.

\_\_\_\_\_  
Patient Signature