# 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 send my medical information (circle one) **FROM // TO**

_____

_____

_____

_____

Please send my medical information (circle one) **FROM // TO**

**Wildflower Natural Medicine**
**1516 SE 43rd 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:

__X__ Medical records needed for continuity of care
____ Diagnostic imaging reports
____ Pathology reports
____ Laboratory reports
____ Other:

_____

_____
Patient signature

_____
Signature of Parent/Guardian if applicable

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