A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Oregon Authorization to Disclose Medical Records

This authorization must be written, dated, and signed
by patient or by a person authorized by law to give authorization.

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I authorize:

To release a copy of the medical information for (Name/DOB):

To: A WellSpring of Natural Health, P.C.
4720 SW Watson Avenue Beaverton, OR 97005
(phone) 503.526.0397 (fax) 503.643.4633

By **initialing** the spaces below, I specifically authorize the release of the following medical records*, if such records exist:

_____ All Chart Notes
_____ Laboratory, Diagnostic and Imaging Reports
_____ Other (please specify) _____
_____ Please send the entire medical records (all information) to the above named recipient.
_____ Most recent 5-year history
_____ Emergency/Urgent care records

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

***The following diagnosis, treatment or referral information must be initialed to be included in other documents:**

_____ *Mental Health Information
_____ *Genetic testing information
_____ *Drug/alcohol use/abuse
_____ *HIV/AIDS related records

Federal regulations require a description of how much and what kind of information is to be disclosed.

Please describe: _____

_____ This authorization is limited to records regarding the following treatment:_____
_____ This authorization is limited to records from the following time period: _____
_____ This authorization is limited to a worker's compensation claim: _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to completed the request.

_____ _____
Date Signature of Patient

_____ _____
Date Signature of person authorized by law/relationship to patient