Request and Authorization to Release Medical Information

Patient Information:

Legal Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby authorize:

Physician/Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

To send the following to: Hillsboro Naturopathic Clinic
245 SE 4th Ave. Ste. E
Hillsboro, OR 97123
P: 503-844-6667 **F: 503-924-5905**

___ Dr. Victoria Lutskovsky ___ Dr. Valerie Netherland
___ Dr. Sierra Carey ___ Kristin Kinnie, MScN, MSW

___ Chart Notes _____
___ Lab Results _____
___ Imaging Reports _____
___ Other _____

I hereby consent to release the above information, including alcohol, drug abuse and mental health records obtained during my diagnosis and treatment. I understand that such information cannot be released without my specific consent, except in the event of medical emergency**. I further understand that this authorization is valid for six (6) months from the date of signing unless revoked in writing earlier.** The only exception is when action has already occurred as instructed in consent.

_____

Signature **Date** **Relationship to patient**

Specifically Protected Information

I understand that a variety of tests have been undertaken and one of them may have been an HIV related test. My signature below authorizes release of any results including HIV related (AIDS) test results.

Signature: _____ Date: _____