Tualatin Internal Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________

Please Note: Copy Fee May Be Charged For Medical Records

Records From:

Facility/Doctor: _______________________________

Address: ____

City, State, Zip: ___________________________________

Phone: _________________________ Fax: ________________________

Dates and Type of information to disclose:

- 2 years chart notes prior from last date seen
- 5 years Imaging and lab results
- Please include all: Colonoscopy, DEXA, Mammogram, Immunizations, sleep study
- Specific Information requested:____

Records To:

Facility/Doctor: _______________________________

Address: ____

City, State, Zip: ___________________________________

Phone: _________________________ Fax: ________________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary of my protected health information to the physician/facility listing about.

X____

Signature of Patient / Parent / Guardian or Authorized Representative Date

____

Printed name of Authorized Representative / Relationship to patient

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