



Abigail Bisson ND Corp

1540 Commercial St SE

Salem, OR 97302

Ph: (503) 581-6239

Fax: (855) 746-9201

### Medical Records Release Form

I hereby authorize Abigail Bisson ND Corp to receive records and information from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE PRINT** Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number : \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### WE ARE REQUESTING:

- ☐ ONE YEAR OF COMPLETE RECORDS, unless specified below.  
(Send the most recent 12 months that the patient was seen.)

### Additionally:

- |  |   |
|--|---|
| <input type="radio"/> Most recent labs                     | <input type="radio"/> HIV/STD results       |
| <input type="radio"/> Drug/Alcohol/Substance abuse records | <input type="radio"/> Most recent Mammogram |
| <input type="radio"/> Most recent Colonoscopy/Endoscopy    | <input type="radio"/> Genetic Information   |
| <input type="radio"/> Psychiatric/Mental health records    | <input type="radio"/> Immunization Record   |
| <input type="radio"/> Most recent Pap smear pathology      | <input type="radio"/> OTHER _____           |

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: \_\_\_\_\_.

The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_