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:

- Most recent labs
- Drug/Alcohol/Substance abuse records
- Most recent Colonoscopy/Endoscopy
- Psychiatric/Mental health records
- Most recent Pap smear pathology
- HIV/STD results
- Most recent Mammogram
- Genetic Information
- Immunization Record
- 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:_____