



Abigail Bisson ND Corp
1540 Commercial St SE
Salem, OR 97302
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Medical Records Release Form

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

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: _____