



Abigail Bisson ND Corp

1540 Commercial St. SE

Salem, OR 97302

Ph: (503) 581-6239

Fax: (855) 746-9201

Medical Records Release Form for Family or Friends

PLEASE PRINT Patient's Full Name: _____

Date of Birth: _____ Phone Number : _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize Abigail Bisson ND Corp to accept payment on my behalf from:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

This Authorization extends to:

- ALL RECORDS (unless specified below.)

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. Check box if you choose no expiration date of your medical release authorization

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: _____