Authorization to Release Medical Records **to** Today Integrative Health + Wellness

By law, this Authorization must be written, dated, and signed by the patient in order to release records.

_____ _____

Name of Patient Date of Birth

_____ _____

Home Phone Number Work Phone Number

I hereby authorize:	***To send my medical records to:***
Name of your other provider:	**Dr. _____**
Their clinic/hospital/agency:	**Today Integrative Health and Wellness**
Street address:	**PO Box 2145**
City, State, Zip code:	**Tualatin, OR 97062**
Phone and Fax numbers:	**Ph: (503) 746-5889 Fax: (503) 208-8025**

This information will be used on my behalf for the following purpose and limited to (Date and Type of Treatment):_____

_____

By **initialing** the spaces below, I authorize the release of the following medical records, if such records exist:

___ Entire medical record ___ Progress notes ___ Laboratory reports

___ Pathology reports ___ EKG ___ Imaging

___ Operative reports ___ Other (please specify_____

The following items must be initialed to be included in other documents:

___ HIV/AIDS related records ___ Mental Health records

___ Drug/ Alcohol diagnosis, treatment or referral information ___ Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed.)

Describe: _____

I understand that such information can not be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for 6 months from the date of signing unless revoked earlier in writing by the patient. The only exception is when the action has already occurred as instructed in the consent.

_____

Signature of Patient or legal guardian **Date**

today
Integrative
Health + Wellness

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