Authorization to Release Medical Records **from** 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:***
Dr. _____	**Name of your other provider:**
Today Integrative Health and Wellness	**Their clinic/hospital/agency:**
PO Box 2145	**Street address:**
Tualatin, OR 97062	**City, State, Zip code:**
Ph: (503) 746-5889 Fax: (503) 208-8025	**Phone and Fax numbers:**

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

PO Box 2145
Tualatin, Oregon 97062
Tel: (503)-746-5889
Fax: (503)-208-8025
www.todayhealthandwellness.com