RELEASE OF RECORDS

I authorize the release of medical information ☐ TO ☐ FROM

Sarah McAllister, ND
4444 SW Corbett Ave.
Portland, OR 97239
Tel: (503) 224-2590
Fax: (503) 224-2592

☐ TO ☐ FROM

Provider: _____

Address _____ City/State _____ Zip _____

Phone _____ Fax _____ Email _____

I specifically authorize the release of the medical records **initialed** below, if such records exist:

_____ Transcribed hospital records from the following time period: _____ to _____

_____ Emergency and urgent care records from the time period: _____ to _____

_____ Diagnostic imaging reports from the following time period: _____ to _____

_____ Clinician / office chart notes from the following time period: _____ to _____

_____ Lab results from the following time period: _____ to _____

_____ Pathology reports from the following time period: _____ to _____

_____ Verbal discussion regarding patient welfare and findings from the following time period: _____ to _____

_____ Other: _____

_____ Entire medical record (The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Print patient name: _____

Patient's date of birth: _____ Patient's social security number: _____

Patient / guardian signature: _____ Date _____