AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I authorize Dr. Mary Scott, ND, LAc to release a copy of the medical information

for_____ _____
(name of patient) (date of birth)

to _____
(new provider name)
_____
(new provider address, zipcode, fax number)

The information will be used on my behalf for the following purpose: disclose records to new provider

By initializing the spaces below, I specifically authorize the release of the following medical records, if such records exist.
( ) clinical office chart notes
( ) lab reports
( ) pathology reports
( ) diagnostic imaging reports
( )
other:_____
( ) please send the entire medical record (all information) to the above named recipient. This record may be voluminous and I agree to pay all reasonable charges associated with providing this record, 20 cents per page.
The following items must be initialized to be included in other documents.
_____ HIV/AIDS related records
_____mental health information
_____genetic testing information
_____drug/alcohol diagnosis, treatment or referral information (Federal regulation require a description of how much and what kind of information is to be disclosed)
Describe_____
_____This authorization is limited to:
_____ records regarding the following treatment_____
_____ records from the following time period _____

This authorization may be revoked at any time. The only exception is when action has been taken on reliance on the authorization. Unless revoked earlier, this consent will expire 100 days from the date of the signing or shall remain in effect for the period reasonably needed to complete the request.

_____(date) _____
(signature of patient)
_____(date)_____
(signature of person authorized by law)

Mailing Instructions

Mary Scott, ND, LAc
216 NE 24th Ave.
Portland, Oregon 97232