Authorization for Release of Medical Information

Patient Information *(Please print)*

Name:_________________________ Date of birth:__________________ SSN:____________________

Address____

Street *City* *State* *Zip*

Authorization to Release Records To ☐ From ☐	Authorization to Release Records To ☐ From ☐
A Healthy State of Mind Mary Fry, N.D. 1940 NE Broadway St. Portland, OR 97232 Tel. 971-678-6243 **Fax: 360-718-8343** **(Please call prior to faxing and/or mail records)**	Clinic/Facility:_____________________________________ Name of Clinician/Provider:___________________________ Address ____ Telephone__________________Fax______________________

_____ Complete Medical Record (excluding sensitive documents*)

Specific medical information:

_____ History and Physical
_____ Laboratory, Imaging Studies, Pathology reports
_____ Electrocardiogram
_____ Hospitalization records/ Discharge summary
_____ Mental Health treatment* *(please initial to authorize release)*
_____ Alcohol abuse diagnosis/treatment* *(please initial to authorize release)*
_____ Drug abuse diagnosis/treatment* *(please initial to authorize release)*
_____ Sexually transmitted infections, HIV/AIDS test results* *(please initial to authorize release)*
_____ Other ____

By signing below, I hereby authorize the release of medical records as noted above.

____ ________________________

Signature (patient) *Date*