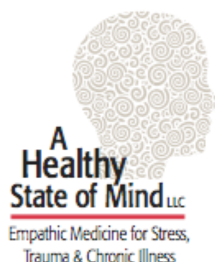

Authorization for Release of Medical Information

Patient Information (Please print)

Name:_________________________ Date of birth:__________________

Address____

City___________________________ State_______ Zip Code__________

Please release my medical records from:

Name of entity or Medical Provider________________________________

Specialty/ Provider type____

Telephone______________________ Fax___________________________

To my medical provider, Mary Fry, N.D. at:

A Healthy State of Mind
1940 NE Broadway St.
Portland, OR 97232
Tel. 971-678-6243
Fax Number: 971-205-5484

Please *initial* items below to be sent to the office of Mary R. Fry, ND:

_____ Complete Medical Record

_____ Laboratory reports

_____ Imaging Studies

_____ Pathology reports

_____ Operative report

_____ Other (please specify)

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

____ ______________________

Signature of Patient or Representative Date