Authorization for the Release of Medical Records

Patient Name: ____ Date of Birth: ___________________
(Also list maiden name/other names used)
I hereby request and authorize:

Live Well Health, PC • PO Box 2415 • Wilsonville, OR 97070
503-855-4465 Phone 971-249-8767 fax

☐ To Disclose Information to: ☐ To Receive Information from:

Name/Provider: ____
Address: ____
City/State/Zip: ____
Phone: ________________________________ Fax: ________________________________
Name/Provider: ____
Address: ____
City/State/Zip: ____
Phone: ________________________________ Fax: ________________________________
Name/Provider: ____
Address: ____
City/State/Zip: ____
Phone: ________________________________ Fax: ________________________________
Name/Provider: ____
Address: ____
City/State/Zip: ____
Phone: ________________________________ Fax: ________________________________

Information to be disclosed includes copies of:

☐ Entire Record ☐ Reports ☐ Physical Exam Forms
☐ X-Ray Reports ☐ CT Scan Reports ☐ Other, specify
☐ Daily Chart Notes ☐ MRI / Reports _____________________

This authorization will be in effect for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature of Patient: ____ Date: _________________
OR
____ Date: _________________
Signature of Legal Representative/ Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient of legal representative.