Orna Izakson, ND, RH (AHG)
4921 NE 28th Ave., Portland, OR 97211
503.335.9479v • 503.575.9229f
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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Celilo Natural Health Center does not offer reimbursement for records received.

Patient Name (Please Print): _____ **Date of Birth:**____/____/____

Address:_____

Phone:_____Fax: _____

Physician and Clinic: _____

Address:_____

_____

Phone:_____Fax: _____

********** **Please release the following information:** **********

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following via telephone consultation:

_____ **All Medical Records Necessary for the Continuity of Care**

_____ **Labs and Diagnostic Imaging Only**

_____ **Other:** _____

Patient Signature: _____ **Date:** ____/____/____

Parent/Guardian Signature (if applicable):_____ **Date:** ____/____/____

********** **Confidential Information** **********

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Celilo Natural Health Center. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ HIV/AIDS test results and related information, including high risk
Patient Signature behavior documentation.

_____ Drug/Alcohol diagnosis, treatment, or referral information.
Patient Signature

_____ Mental Health information.
Patient Signature

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

_____

_____

_____

********** **Please fax or mail as soon as possible to:** **********

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