AUTHORIZATION TO DISCLOSE MEDICAL RECORDS
Oregon Revised Statute 192.525, 1997

This authorization must be dated and signed by the patient or guardian of the patient.

I authorize ____

phone_________________fax_________________to release a copy of the medical

Information for ______________________Patient phone ____________________
d.o.b.___ ______________ HRN:____________________ to
Holistic Health Clinic * 4670 SW Washington Ave, OR 97005 (503) 646-8575 * Fax (503) 526-0783.

The information will be used on my behalf for the following: CHIROPRACTIC TREATMENT.

I authorize the release of the following medical records:

INITIAL NEXT TO ALL THAT APPLY

___All hospital records (including nursing records and progress notes)
___Emergency and urgency care records
___Please send the entire medical record.
___Most recent five year history
___Lab /Pathology reports
___X-Ray / Special Imaging REPORTS only
___Physical therapy records
___X-Rays
___Other
____

AUTHORIZATION RESTRICTED TO THE FOLLOWING TIME PERIOD: ___________________to CURRENT

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

________________ (date) **_________________________________**
(Signature of patient/guardian)