Kristen Plunkett, ND
1200 NE 7th Street, Grants Pass, OR 97526
Phone: 541-476-2916 Fax: 541-476-9763

Authorization to Disclose Medical Records

This authorization must be completed entirely by the patient by law to give authorization.

Name of Patient _____ Date of Birth _____

I hereby authorize the release of records:

☐ **TO** ☐ **FROM** ☐ **TO** ☐ **FROM**

Doctor/Individual	Doctor/Individual
Name of Clinic/Hospital/Agency	Name of Clinic/Hospital/Agency
Address	Address
City State Zip	City State Zip
Phone Fax	Phone Fax

For the purpose of: _____ Continuity of Care _____ Transfer of Care

Description of information to be released: (**Initial** all that apply) Dates: _____

_____Laboratory Reports	_____Last 2 years of medical record
_____Radiology/Imaging Reports	_____Entire medical record
_____Most recent history and physical	_____Billing records

Other: _____

If medical records exceed 25 pages, please mail. **Do not fax.**

By ***initialing*** the spaces below I authorize the release of the following medical records, if such records exist:

_____HIV//AIDS related record	_____Mental health records
_____Substance abuse	_____Genetic testing information

I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for 1 year from the date of signing unless revoked in writing by me. The only exception is when the action has already occurred as instructed in this consent.

Signature of patient, legal guardian (if patient under 13 years of age), or legal power of attorney _____ Date _____