Optimal Behavioral Health
11160 Highway 62, Suite B
Eagle Point, OR 97524
(541) 826-0899
Fax (541) 826-2234

Authorization to Release Medical Information to/from Melanie Kabot-Sturos, PMHNP-BC, MSN or Curt Sturos, MD:

Patient Name _____ DOB _____ Former Name_____

Current Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____ SSN _____

I authorize information released to/from:

_____
Physician/or third party named

_____
Address

_____
City, State, Zip

Please send my records to/from:
Optimal Behavioral Health
PO Box 159
Shady Cove, OR 97539
***OR* Fax (541) 826-2234**

Indicate Type of Information to be Released Below:

- ☐ General Medical Records including progress notes, lab reports and immunization records

-OR-

Specific Information Only:

- ☐ History and Physical — specify date _____
- ☐ Medications/Therapy
- ☐ Lab, EKG — specify type or date _____
- ☐ Accident or injury — dates from _____ to _____
- ☐ Immunizations only
- ☐ Other _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING, I authorize the release of the following protected or sensitive information:

_____ DRUG ABUSE DIAGNOSIS/TREATMENT _____ SEXUALLY TRANSMITTED DISEASES

_____ ALCOHOLISM DIAGNOSIS/TREATMENT _____ AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR

_____ MENTAL HEALTH/TREATMENT _____ GENETIC TESTING

- By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information.
- You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.
- You are under no obligation to sign this form, and you may refuse to do so. Treatment and payment may not be conditioned on signing this authorization.

_____

Signature of patient or guardian **Date**