AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By signing this form, I authorize the release of my medical records to

Holistic Health Clinic
4670 SW Washington Ave Beaverton, OR 97005
***Phone (503) 646-8575 * Fax (503) 526-0783**

Patient's name_____

Patient phone: _____ D.O.B: _____

Facility / Physician's name_____

Phone: _____ Fax: _____

___Medical Records

____Emergency and urgent care records

____Lab /Pathology reports

____Imaging REPORTS only (X-ray, MRI, CT, US)

___ Please include copies of images / CD's

___Other _____

Dates from_____**to**_____

_____ **(date)** _____

(Signature of patient/guardian)