

Authorization To Disclose Medical Records



Gregory Garcia ND, LAc
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TO: _____

(Name or other specific identification of the person or class of persons authorized to disclose the health information, i.e., the medical provider)

This will authorize you to furnish to Greg Garcia, ND, LAc by mail or fax the complete medical records in your possession, including but not limited to reports, correspondence, examinations and test results, regarding the individual identified below:

Name:

DOB:

The disclosure of medical records is for continuity of care. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that these records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released as noted below.

INCLUDE the following information from the records (please initial):

___ Drug/Alcohol abuse/treatment & diagnosis

___ Sexually Transmitted Disease

___ HIV/AIDS diagnosis/treatment/testing

___ Mental Illness or Psychiatric Diagnosis

For the specific purpose of (describe in detail):

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

Signature of Patient or Patient's Authorized Representative

Date

Patient Representative's Relationship to Patient _____