willamette integrative health

25195 SW Parkway Ave Ste 210 ▪ Wilsonville, OR 97070-9689
P/ 971.245.2185 ▪ F/ 971.248.2096 ▪ willametteintegrative.com

MEDICAL RECORDS AUTHORIZATION

Patient name	
Date of birth	**Phone number**

RELEASE FROM:

Provider name: ____

Facility name: ____

Address: ____

____

Phone: ____

Fax: ____

RELEASE TO:

Dr. Elizabeth Sedlak @ Willamette Integrative Health
25195 SW Parkway Ave Ste 210 Wilsonville, OR 97070-9689
971-248-2096 fax

PURPOSE FOR RELEASE: ☐ continuity of care ☐ transfer of care ☐ other: ____________________

INFORMATION TO BE RELEASED: (date range: ________________) ☐ chart notes ☐ entire record

☐ labs or imaging ____

☐ other: ____

* Additional laws apply to the use and disclosure of the following information. **You must <u>initial</u> each category for it to be released**:

_____ genetic testing information _____ drug/alcohol treatment _____ mental health information _____ HIV/AIDS status

SIGNATURE: ____ Date: ________________

patient or guardian signature

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