Authorization for Release of Medical Information

Patient Name: ____

Date of birth: ________________ Phone number: ______________________

Please complete as much of the following information as you know.

From: ____
Doctor or facility name

____
Address, City, State, ZIP

____
Fax number /Phone number

To: ❑ **Dr. Jill Edwards,** ❑ **Dr. Katherine Zieman,**

❑ **Dr. Kathryn Kloos,** ❑ **Dr. Madeleine Portuondo**

22400 SE Stark St, Gresham, OR 97030

Fax: 503-200-1094 Phone: 503-492-1221

I understand that my consent is required for the release of my medical records under state and federal law. I hereby consent to the release of all information noted below:

___ 2 years prior from the last date seen

___ Laboratory results

___ Imaging reports

___ Other: ____

____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature of Patient or Legal Guardian ____________________________ Date______

Relationship (if signed by a representative) ______________________________________