Southern Oregon Internal Medicine
2900 Doctors Park Drive
Medford, OR 97504

Authorization to Release Medical Information

Patient: _____ Birth Date: _____

I consent to the release of Medical Information (records):

To:

Haki Lee, FNP-C
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2200
Fax: (541) 842-9691

From: (Physician, Clinic, or Person)

_____
_____
_____
_____
_____

Information to be released:

_____ Standard Problem List, Medication Summary, Progress Notes, Health History Immunization Records, Letters, X-ray & Laboratory Reports. From Date: _____ To Date: _____

_____ X-ray reports only. Date(s): _____

_____ Laboratory and Pathology reports only. Date(s): _____

_____ Other tests or studies (list type of test/study and date performed): _____

_____ Other (specify): _____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record.
***(Initial if release is authorized)**

_____ Drug and alcohol abuse

_____ Information related to diagnosis/treatment of HIV

Please note that a separate release is required for Behavioral Health Information

Purpose of Disclosure:

_____

_____

This authorization is valid for six months after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

_____ _____

Signature of patient or legally authorized representative Date