Southern Oregon Internal Medicine
2900 Doctors Park Drive, Suite 200
Medford, OR 97504

Authorization to Release Medical Information

Patient:_____ Date of Birth: _____

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

To:

Dr. William C. Husum
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2200
Fax: (541) 282-2260

From: (Physician, Clinic, or Person)

_____
_____
_____
_____
_____

****PLEASE SEND RECORDS ON CD IF POSSIBLE****

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