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

Authorization to Release Medical Information

Patient:____________________________ Date of Birth: ___________________

Patient: ____________________________ Date of Birth: ___________________

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

To:

Dr. Albert Newton
2900 Doctors Park Drive
Medford, OR 97504
Phone:(541) 282-2200
Fax: (541) 282-2238

From: (Physician, Clinic, or Person)

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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:

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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

Mail to address above or fax to: (541) 282-2238