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:	**From: (Physician, Clinic, or Person)**
Dr. Christopher Murphy	_____
2900 Doctors Park Drive	_____
Medford, OR 97504	_____
Phone: (541) 282-2200	_____
Fax: (541) 282-2266	_____

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