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 Medication Information (records):

To:

Dr. George Schultz
2900 Doctors Park Dr. Suite 200
Medford, OR 97504
Phone: (541)282-2200
Fax: (541)842-9691

From: (Physician, Clinic, or Person
Include phone &/or fax#)
_____
_____
_____
_____
_____

****PLEASE SEND RECORD ON CD OR THUMB DRIVE IF POSSIBLE****

Information to be released: (initial each line that applies)

_____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, Diagnostic & Laboratory Reports. From Date: _____ To Date: _____
_____ Diagnostic reports only. Date(s): _____
_____ Laboratory and Pathology reports only. Date(s): _____
_____ Other test 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 at 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