SOUTHERN OREGON INTERNAL MEDICINE
2900 Doctors Park Drive, Suite 200
Medford, OR 97504

Authorization to Release Medical Information

Patient: _____ Birth date: _____/_____/_____

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

To: (Physician, Clinic, or Person)

Name: Julie Graham, FNP-C
Address: 2900 Doctors Park Dr. Suite 200
City/State/Zip: Medford, OR 97504
Phone: 541-282-2200
Fax: 541-282-2275

From: (Physician, Clinic, or Person)

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

****PLEASE SEND THE RECORD ON CD OR THUMB DRIVE WHEN POSSIBLE; DO NOT FAX MORE THAN 25 PAGES****

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 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 of behavioral health information is required.

Purpose of Disclosure:

_____
_____

****A charge of $25.00 for the first ten (10) pages and .28 cents for each page over ten (10) may apply.**

This authorization is valid for six months after the date of signature. If the undersigned provides written notice of revocation, it may be revoked at any time (but not retroactively to a release of information made in good faith).

_____ _____
Signature of patient or legally authorized representative Date