



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: (Physician, Clinic, or Person)

From: (Physician, Clinic, or Person)

Name: Dr. Dorothea Murray, DO

Name: _____

Address: 2900 Doctors Park Dr. Ste 200

Address: _____

City/State/Zip: Medford, OR 97504

City/State/Zip: _____

Phone: 541-282-2200

Phone: _____

Fax: 541-282-2265

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