

Bridges Family Wellness PC



Authorization for Release of Medical Information

Patient Name: _____

Date of birth: _____ Phone number: _____

Please complete as much of the following information as you know.

From: **Bridges Family Wellness**
7831 SE Lake Rd, Suite 102
Milwaukie, OR 97267
Phone: 503-575-1275
Fax: 503-549-5619

To: _____
Doctor or clinic name

Street Address

City, State, ZIP

Phone number

Fax number

I understand that my consent is required for the release of my medical records under state and federal law. I hereby consent to the release of all information noted below. This consent is valid for 6 months from the date of signature.

Chart Notes
 Laboratory results
 Imaging reports
 Other _____

Signature of Patient or Legal Guardian _____ Date _____

Relationship (if signed by a representative) _____