## 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: ____________________________________________________
Doctor or clinic name

____________________________________________________
Street Address

____________________________________________________
City, State, ZIP

____________________________________________________
Phone number

____________________________________________________
Fax number

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

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) _________________________