Bridges Family Wellness PC

Authorization for Release of Medical Information

Patient Name_____

Date of Birth_____ Phone Number_____

Circle one **To forward records to**
To receive records from

Bridges Family Wellness
7831 SE Lake Rd Suite 102
Milwaukie, OR 97267
ph. 503.575.1275
fax. 503.549.5619

Circle one **To forward records to**
To receive records from

TO THE MEDICAL RECORDS OFFICE: Send records from the last two years, unless otherwise noted. Fax or mail only, no CDS

Doctor or clinic name_____

Address_____

City_____**State**_____**Zip**_____

Phone_____**Fax**_____

PUROSE OF RELEASE

Circle one **Changing healthcare provider**
Referral to specialist
Consultation

I understand the 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.

PLEASE INITIAL

_____Chart Notes _____Imaging Reports _____Mental health

_____HIV/AIDS _____Drug/Alcohol _____Genetic Testing

_____Laboratory Results _____ OTHER_____

SIGNATURE OF PATIENT_____**Date**_____

RELATIONSHIP(If signed by representative)_____