JENNIFER O'LEARY, ND
PO Box 22559
Milwaukie, OR 97269
P. 503.387.3348 F. 503.387.3347

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____

Previous Name _____

Date of Birth _____ Phone _____

I AUTHORIZE RELEASE OF INFORMATION FROM:

Name of physician or facility: _____

Street Address: _____

City, State, Zip: _____

TO:

Dr. Jennifer O'Leary ND | PO Box 22559 | Milwaukie, OR 97269 | F. 503.387.3347

1. I understand that my records are protected under state and federal confidentiality laws and that my written consent is required for their release. I authorize the above named facility to release the following information, via written or verbal communication.

- ☐ All medical records including x-ray and lab reports
- ☐ Only medical records from (date) _____ to (date) _____
- ☐ Only medical records pertaining to
- ☐ Only lab reports from (date) _____ to (date) _____

_____ _____

Signature of patient or legal guardian Date

2. I specifically authorize release of the following information:

- ☐ Alcohol and drug treatment information
- ☐ Mental health treatment information
- ☐ Sexually transmitted disease release information
- ☐ HIV/AIDA testing information/results

_____ _____

Signature of patient or legal guardian Date

3. I specifically consent to the transmission of my medical records by a fax machine.

_____ _____

Signature of patient or legal guardian Date

Consent may be revoked at any time. The only exception is when the action has already occurred as instructed in this consent.