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Records Release Request

Physician/Recipient: _____ Date: _____
Phone: _____ Fax: _____
Street Address: _____
City/State: _____ Zip Code: _____

Patient Name: _____ DOB: _____

Other comments: _____

Information to be released:	Purpose of Disclosure:
<input type="checkbox"/> CHART NOTES (dates from/to: _____)	<input type="checkbox"/> Referral/patient request/other: _____
<input type="checkbox"/> LABS (dates from/to: _____)	<input type="checkbox"/> Mental Health Information _____ patient initials
<input type="checkbox"/> PATHOLOGY REPORT (dates from/to: _____)	<input type="checkbox"/> Genetic Testing Information _____ patient initials

Patient Signature: _____ Date: _____

Please call 503-223-3104 if you have any questions. We appreciate your assistance.

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signature or shall remain in effect for the period needed to complete the request.

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