RELEASE OF RECORDS

I authorize the release of medical information TO or FROM

Heidi Peterson, ND
7005 NE Glisan St, Suite A
Portland, OR 97213
Tel: 503-546-7663
Fax: 503-505-7672

TO or FROM

Provider:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

I specifically authorize the release of medical records marked below, if such records exists:

_____ Lab Results / Pathology Results

_____HIV Information: Additional patient signature required _____

_____ Imaging Reports

_____ Chart Notes

_____ Emergency / Urgent Care

_____ENTIRE MEDICAL RECORDS (The recipient understands there may be a fee for voluminous records and agrees to pay any charges associated with sending)

_____ VERBAL Communication regarding patient welfare and findings

_____ OTHER

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

Patient/Guardian Signature: _____Date:_____

Printed Patient Name: _____ D.O.B. _____