Elements Holistic Wellness
15 82nd Dr. Suite 100, Gladstone, OR 97027 P: 503-656-5510

Authorization to Disclose Medical Records

I authorize _____ (name of hospital/health care provider) to release a copy of the medical information for _____(name of patient) to **Elements Holistic Wellness**.

DOB: _____

This information will be used on my behalf for the following purpose(s):

Ensure effective patient care._____
_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____All hospital records (including nursing record and progress notes)
_____Transcribed hospital records
_____Medical records needed for continuity of care
_____Most recent five year history
_____Laboratory results
_____Pathology reports
_____Diagnostic imaging reports
_____Clinician office chart notes

_____Dental records
_____Physical therapy records
_____Emergency and urgency care records
_____Billing statements
_____Other

_____HIV/AIDS related records*
_____Mental health information*
_____Genetic testing information*
_____Drug/alcohol diagnosis, treatment, or referral information**

**Must be initialed to be included in other documentation.*
***Federal Regulation, 42 CFR Part 2 requires a description of how much and what kind of information is to be disclosed.*

_____This authorization is limited to the following treatment: _____

_____This authorization is limited to the following time period: _____

_____This authorization is limited to a worker's compensation claim for injuries on _____ (date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
Date Signature of patient or person authorized by law

Oregon Revised Statute 192.525, 1997