AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization

Patient name _____ DOB:_____

Any other names patient has been known by:

_____

Phone Number_____

I authorize the exchange of medical information between:

_____

_____

_____ and

_____

_____

Christina Peterson MD

15259 SE. 82nd Dr. Ste 201B

Clackamas, Oregon 97015

Phone: 503-656-9844

Fax: 503-656-3120

I specifically authorize the release of the outpatient medical records:

Additional authorized items – initial if approved

___ All hospital records

___ Laboratory reports

___ Mental Health Information

___ Genetic testing information

___ Transcribed hospital records

___ Diagnostic imaging reports

___ HIV/AIDS related records

___ Drug/Alcohol diagnosis treatment

___ This authorization is limited to the following time period: _____

Unless revoked earlier, this consent will expire 365 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 legal guardian