7000 SW Hampton St.
Suite 130
Tigard OR 97223
Phone 503-639-3777 - Fax 503-639-1120

Renee Schwartz, ND Nathalie Paravicini, ND Wendy Hodsdon, ND Beverly Ki Hacely, AP, ND Karen Davis, MS, CNS, NTP

RELEASE OF INFORMATION

Patient Name____ DOB_______________________

Address ____

Phone_______________________ Parent/Guardian____

RELEASE TO (who you want to have access to your records):

☐ NW Naturopathic Medicine
☐ Self
  ☐ Email records to______________________________
  ☐ Hard copy mailed or available for pick up in office

☐ Parent/Guardian/Other **via** ☐ Phone ☐ Patient Portal ☐ Email:_________________________

First Name_____________________ Last Name ____________________ Phone #_________________

☐ Outside Clinic:
Practice Name ___________________________ Provider's Name_______________________

Address ____

Phone________________________________ Fax_________________________________

RELEASE FROM (who has your records):

☐ NW Naturopathic Medicine
☐ Outside Clinic:
Name of facility ________________________Provider's Name_________________

Address ____

Phone_____________________________ Fax______________________________

I authorize the above physician/clinic/hospital to release written records by checking the boxes pertaining to the following information. I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. **THIS AUTHORIZATION EXPIRES 360 DAYS AFTER IT IS SIGNED.**

☐ **All Medical Records** ☐ **Labs and Diagnostic imaging** ☐ **Other:** _________________________________

Purpose of release: ☐ Transfer of care ☐ Coordination of care ☐ Referral/Consultation ☐ Personal Use

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No I authorize the release of any records regarding genetic testing to the person(s) listed above.

Patient/
Representative
Signature: ____ Date Signed: ____________________