Miles Hassell MD
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AUTHORIZATION TO RELEASE MEDICAL RECORDS TO:

Miles Hassell, MD
Providence St. Vincent Medical Center
9155 SW Barnes Road, Suite 302
Portland, OR 97225

Please complete this form and bring to your office visit.
Medical records may be requested by the physician after your appointment.

Please print:

PATIENT NAME _____ DOB _____ SSN _____

I authorize information to be released from:

PROVIDER NAME		PROVIDER NAME	
PHONE		PHONE	
FAX		FAX	

Type of Information to be released:

☐ **General Medical Records**: Two (2) years of information including progress notes, lab and x-ray reports and immunizations
☐ **Other**: _____

Protected or sensitive information:

I understand that certain information cannot be released without specific authorization.
By placing my **initials** in the applicable spots I authorize the release of the following information:

_____ INITIAL ALCOHOLISM DIAGNOSIS, TREATMENT, OR REFERRAL
_____ INITIAL DRUG ABUSE DIAGNOSIS, TREATMENT, OR REFERRAL
_____ INITIAL GENETIC TESTING
_____ INITIAL SEXUALLY TRANSMITTED DISEASES
_____ INITIAL HIV/AIDS RESULTS OR DIAGNOSIS
_____ INITIAL MENTAL HEALTH

This consent may be revoked by the signed at any time except to the extent that release information has already occurred. Unless otherwise noted, this consent will expire in 90 days.

SIGNED _____ DATE _____

NOTE: please mail large volume records - do not fax - Thank YOU!