

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