Miles Hassell MD | David Ellis MD
Internal Medicine + Lifestyle Medicine
Comprehensive Risk Reduction Clinic
goodfoodgreatmedicine.com

9155 SW Barnes Road, Suite 302
Portland, OR 97225
Voice: (503) 291-1777
Fax: (503) 291-1079

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO:

Miles Hassell MD
David Ellis 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:

______ 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 INITIAL

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!