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.

Please send the entire medical record (all information) to the above name recipient. The recipient understands this record may by voluminous and agrees to pall all reasonable charges associated with	I authorize	to release a copy of the medical information
(Name Of Patient) 9701 SW Barnes Rd., Suite 140, Portland, OR 97225 The information will be used on my behalf for the following purpose(s): Please send information including the diagnosis and records of any treatment or examination rendered to me during the period from		
The information will be used on my behalf for the following purpose(s):		to Northwest Vascular Consultants, Inc
Please send information including the diagnosis and records of any treatment or examination rendered to me during the period from		
Please send information including the diagnosis and records of any treatment or examination rendered to me during the period from	9701 SW Barnes Rd., Suite 14	0, Portland, OR 97225
Please send information including the diagnosis and records of any treatment or examination rendered to me during the period from	T	
By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist: Please send the entire medical record (all information) to the above name recipient. The recipient understands this record may by voluminous and agrees to pall all reasonable charges associated with providing this record. Most recent history – last yrs. / moHospital records Clinician office chart notes Diagnostic imaging reports Billing statements Laboratory reports Pathology reports Correspondence (permission for communication between provider and recipient) HIV/AIDS related records (Must be initialed to be included in other documents.) Mental health information (Must be initialed to be included in other documents) This authorization is limited to the following treatment: This authorization is limited to the following time period: This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. (Date) (Date) (Signature of patient or person authorized by law)	The information will be used on my behalf for	the following purpose(s):
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