In Health Naturopathic Medicine
4150 Pacific Avenue, Suite 300
Forest Grove, OR 97116
Ph 503.357.3074 Fax 503.992.8300

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize:

_____
Name heath care professional/authorized individual

_____
Name of clinic/hospital/agency

_____
Address

_____
City State Zip

_____ _____
Phone Fax

Patient Information

_____
Patient's Name

_____ _____
Date of Birth Phone Number

_____
Address

_____
City State Zip

To send my medical records to:

Crystal Hannan, ND
4150 Pacific Avenue, Suite 300
Forest Grove, OR 97116
Fax 503.992.8300

By INITIALING, I authorize the release of the specific confidential information (please indicate date ranges and specific requests):

☐	Progress Notes/Exam notes _____
☐	Lab Results _____
☐	X-ray/Imaging Reports _____
☐	Mental Health Record _____
☐	Alcohol/Drug Treatment Records _____
☐	HIV-Related (AIDS) test results _____
☐	Other (Please Specify) _____

I hereby consent to release the above information obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for six months from the date of signing unless revoked in writing earlier. The only exception is when the action has already occurred as instructed in the consent.

_____ _____ _____
Signature of Patient, Guardian, or Legal Representative Date Relationship to Patient