Choices for Health, PC

RECORDS RELEASE TO OUR OFFICE

*Please fill in the fields below with the information of your previous provider whom we will be requesting your records **from***

Office or Doctor's Name:

Address:

Phone: Fax:

I, the undersigned, authorize and request that a copy of my medical records be released from the entity indicated above to the office of:

Choices for Health, PC
Gayle Hand, ANP
390 West 12th Ave
Eugene, OR 97401
Fax: (541) 683-4405 *PH: (541) 683-4404*

The following information may be included in this request:

- ❑ All healthcare information in my medical record
- ❑ Healthcare information relating to the following treatment, conditions, or dates: _____
  _____
- ❑ Other: _____
  _____

Additionally I authorize the disclosure of information regarding testing, diagnosis, and treatment for:

- ❑ Drug and / or Alcohol Abuse
- ❑ Mental Health / Psychiatric Conditions
- ❑ Sexually transmitted diseases / reproductive issues
- ❑ HIV (AIDS virus)

I specifically *exclude* the following from being used or disclosed: (Please Specify)

_____
_____

My signature below indicates that:
I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment). The recipient of these records cannot transfer them to another party without expressed consent from the patient or authorized guardian. I understand that I may revoke this authorization in writing at any time. If I do so, this will not affect any actions already taken by the releasing entity identified above in accordance with this authorization.

Print Patient's Name:	Date of Birth:
Signature of patient / representative:	Date:

PLEASE RETURN A COPY OF THIS PATIENT AUTHORIZATION FORM WITH RECORD