AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ DOB _____

Patient Phone number _____

I authorize _____
(name of healthcare provider/facility)

_____
(address, City, State, Zip Code)

_____ _____
(fax number) *(phone number)*

To release my healthcare information to:

DeWayde Perry, MD
Oregon Healing Center
1401 #B Market St. Springfield, OR 97477
Phone 541-844-1708 Fax 541-515-6957

This request and authorization apply to:

Pages documenting the diagnosis of _____
___ Last Visit Only
___ Hospital Records
___ Most recent TWO YEAR history of progress notes
___ Emergency and Urgent Care Records
___ Entire Medical Record

This release expires 180 days from the date of signing

Patient signature_____

Date signed _____

OFFICE USE ONLY

- Date faxed
- Date of Appt
- Date progress notes received