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 authorization.

I authorize **PAUL S MILLER, D.O., 3701 Carman Drive, Lake Oswego, OR 97035** to release a copy of the medical

information for__________________________________ to: ____

____

____

The information will be used on my behalf for the following purpose(s): ____.

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____All hospital records (include. Nursing records and progress notes)
____Transcribed hospital records
____Medical records needed for continuity of care
____Most recent five year history
____Laboratory reports
____Pathology reports
____Diagnostic imaging reports
____Clinician office chart notes
____Dental records
____Physical therapy records
____Emergency and urgency care records
____Billing statements
____Other____

____Please send the entire medical record (all information) to the above named recipient. The recipient understands this record my be voluminous and agrees to pay all reasonable charges associated with providing this record.
____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)***
____Genetic testing information ***(must be initialed to be included in other documents)***

____Drug/alcohol diagnosis, treatment or referral information: ***(Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information below.)***
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____This authorization is limited to the following treatment:____
____This authorization is limited to the following time period:____
____This authorization is limited to a workers compensation claim for injuries of ________________________________(date)

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) (Signature of patient or person authorized by law)