Dr. Wendy Rogers
NATUROPATHIC MEDICINE AND ACUPUNCTURE

Foundations for Health
12570 SW 69th Ave, Ste 101
Tigard, Oregon, US - 97223

Medical Records Release Form (2021)

Medical Records Release Form

This authorization must be written, dated and signed by the patient or by a patient authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursements for records received.

Patient Name: *

Date of Birth: *

I authorize Dr. Wendy Rogers, Foundations for Health, LLC to either obtain or release records as follows: *

- ☐ Obtain records FROM another provider or clinic
- ☐ Release records TO another provider or clinic
- ☐ Discuss my healthcare with a specified family member or other authorized person
- ☐ Discuss my billing details with a specified family member or other authorized person

Name of person, Clinic and/or Agency: *

Mailing Address. Please provide complete address if possible. *

Phone number: *

Fax:

I authorize the disclosure of the following information: *

- ☐ All Medical Records (for the past year)
- ☐ Pathology Reports (for the past 5 years)
- ☐ Chart Notes Only (for the past year)
- ☐ Laboratory Tests (for the past 2 years)
- ☐ Diagnostic Imaging Reports (for the past 5 years)
- ☐ Disclosure to a family member or other authorized person as described above

Please initial to indicate you wish to share information per the selected options above *

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Protected or Sensitive Information. I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By choosing the following you agree to release the indicated information:

☐ Drug/Alcohol information that is protected by federal and state law. I specifically consent to disclose such information.	☐ Mental Health information that is protected by federal and state law. I specifically consent to disclose such information.	☐ HIV/AIDS testing and related information including high risk behavior documentation. I specifically consent to disclose such information.

PATIENT SIGNATURE _____

Date: _____

Name of Guardian/Guarantor: _____

Guardian/Guarantor SIGNATURE: _____

Date: _____