# Medical Record Release Form

Please RELEASE Information to:

Kenneth Meigs, DO
Bloom Functional Medicine
15  82nd Drive, Suite 100, Gladstone, OR 97027
phone:  503-831-9231, fax: 503-656-8080

Patient Name: _____ Date of Birth_____

Address: _____City/State/Zip_____

Phone:_____

Please RELEASE Information FROM:

Orchards Family Medicine
9300 NE Vancouver Mall Dr. Suite 201
Vancouver, WA 98662-8206
Phone: (360) 567-0488
Fax: (360) 567-0489

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:
Progress notes, labs, imaging, health maintenance, vaccination records for the purpose of patient care
List specific dates of records to be released: _____
Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows:

The following must be INITIALED by the requestor to be included in the use and/or disclosure:
_____*HIV/AIDS related information and/or records _____Mental Health Information
_____Genetic Testing information _____**Drug/alcohol diagnostics, treatment, or referral information

*This information may not be re-disclosed without the specific written authorization of the individual, except where authorized by law. **Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed. Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see back of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see back of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature:_____
(Patient/legal representative) Date

If signed by other than patient, indicate relationship:_____