Circle of Health Clinic

Request and Authorization to Release Medical Information

I hereby authorize:

_____
Name of person to authorize release of information

_____
Name of Clinic / Hospital / Agency

_____
Street Address

_____
City State Zip Code

To send my medical records to:

Allan A. Harris N.D., L.Ac.
Circle of Health Clinic
21063 Don Street, Unit 2
Bend, OR 97701
Phone: 541-617-1195
Fax: 541-317-4703

Patient Information

_____
Patient's Name Date of Birth

_____
Social Security Number Phone Number

_____
Street Address

_____
City State Zip Code

By **INITIALING**, I authorize the release of the following specific confidential information.

_____ Health Records (*please specify)*
_____
_____
_____ Lab Results
_____ X-Ray Reports
_____ X-Rays
_____ Other (please specify)
_____

I hereby consent to release of the above information, including alcohol, drug abuse and mental health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent except in a medical emergency. I further understand that ***this authorization is valid for six months from the date of signing unless revoked in writing earlier****. The only exception is when the action has already occurred as instructed by consent.*

X_____ _____ _____
Signature: Patient, Guardian, Legal Representative Date Relationship to Patient

Specifically Protected Information

I understand that a variety of tests have been undertaken and one of them may have been an HIV-related test. My signature below authorizes release of any test results including any HIV-related (AIDS) test results.

_____ _____
Signature Date