AUTHORIZATION TO RELEASE INFORMATION

Patient's Full Name:_____

DOB:_____ SSN#_____ Phone #:_____

I authorize information to be released (**circle to or from for each address as appropriate**):

To or **From:** Jennifer Wallace MD
1235 SE Division St, Ste 208
Portland OR, 97202
Phone/Fax: 888-480-1115

From or **To:** Clinic Name:_____
Physician Name:_____
Address:_____
_____
Phone:_____ Fax:_____

Type of Information Requested: (circle one)

General medical records including office visits, vaccinations, medications, lab/imaging results, etc.

Specific information only. Please indicate requested information:_____
_____
_____

Protected or **Sensitive** information.

*Authorize by initializing the approved topics:

_____alcohol or substance abuse diagnosis/treatment

_____HIV/AIDS related information including relevant high risk behaviors

_____sexually transmitted diseases

_____mental health treatment

_____genetic testing

Signature of Patient or Guardian:_____ **Date:**_____

This authorization is valid for 90 days and may be revoked by the patient at any time therein.