EMERALD LEAF INSTITUTE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name ____ Date of birth______/______/______

Authorization Request to____
(Doctor or Medical Office Name)

____
(Address)

____
(Phone #) (Fax #)

I hereby authorize the release of the indicated medical records within the specified date range, for the purpose of continuing care:

From period ________ to________

___X___ Documentation of diagnosis ___X___ Physician/clinician chart notes

_______ Radiology records _______ Other Records (list clearly) __________________

____

I also authorize the release of the following specific medical records.
YOU MUST INITIAL THE SPECIFIC RECORDS INDICATED. PLEASE DO NOT PLACE A CHECK OR "X" IN THE SPACE PROVIDED.

______HIV/AIDS related records ______Mental Health records ____Drug and/or Alcohol-related records

Please inform us in writing if you would like this authorization to be revoked. Send request to:
Emerald Leaf Institute, PO Box 11423, Portland, OR 97211, Attn: Medical Records

I hereby acknowledge that I fully understand the contents of this form understand and authorize release of medical information.

Print Name____

Signature____

Please Return This Form To:

Emerald Leaf Institute, PO Box 11423, Portland, OR 97211, Attn: Medical Records
Phone: (503) 284-LEAF

Emerald Leaf Institute is committed to providing a safe, secure and private environment for our patient's peace of mind. We will not release any patient information to any third parties, unless requested in writing by the patient or required by law enforcement and/or court order.

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