

Release of Records

I authorize the release of medical information:

TO:

___ Alison McAllister, N.D. ___ Sarah McAllister, N.D.
___ Heidi Peterson, N.D. ___ Laura Rubiales, N.D., L.Ac.

At the following address: 4444 SW Corbett Ave, Portland, OR 97239.
Phone: (503) 224-2590 Fax: (503) 224-2592

FROM:

PROVIDER
ADDRESS
ADDRESS 2
CITY/ STATE/COUNTRY
ZIP
PHONE
FAX
E-MAIL

I specifically authorize the release of the medical records initialed below, if such records exist:

___ Transcribed hospital records from the following time period: _____ to: _____
___ Emergency and urgent care records from the time period: _____ to: _____
___ Diagnostic imaging reports from the following time period: _____ to: _____
___ Clinician/office chart notes from the following time period: _____ to: _____
___ Lab results from the following time period: _____ to: _____
___ Pathology reports from the following time period: _____ to: _____
___ Verbal discussion regarding pt welfare and findings from the following time
period: _____ to: _____
___ Other: _____
___ Entire medical record (The recipient understands this record may be voluminous and
agrees to pay all reasonable charges associated with providing this record).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

(Patient/Guardian Signature) Date: _____

(Patient's Date of Birth) _____
(Patient's Social Security Number)