



Release of Records

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

As required by the Privacy Regulations, Red Leaf Natural Health may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: _____

Address: _____ to disclose my patient health information the Red Leaf Natural Health Clinic.

Please mail the records to:

**Red Leaf Natural Medicine
833 SW 11th, Suite 1018
Portland, Or 97205**

Or Fax my information to:

Red Leaf Natural Health fax number: 503-224-3397

By initializing the spaces below, I authorize the release of the following records to Red Leaf Natural Health, if such records exist:

_____ Entire Medical Record _____ Progress Notes _____ Laboratory report
_____ Pathology reports _____ EKG _____ Diagnostic Imaging report
_____ Operative report _____ Other, specifically: _____

This authorization will expire in 180 days from the date of signing.
I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I have read and understand the Notice of Privacy Practices of Red Leaf Natural Health regarding my health information and understand that I have the right to revoke this authorization in writing at any time. I understand that I do not have to sign this authorization and may request a copy of it at any time.

Date: _____

Signature of Patient or Authorized Representative (relationship)

833 SW 11th Ave, Ste 1018, Portland OR 97205
Phone (503) 224-2525 Fax (503) 224-3397