Raina Lasse, ND
Listen. Understand. Heal.

Release of Records

Patient Name:_____ Date:_____
Address:_____
Phone:_____ Date of Birth:_____

As required by the Privacy Regulations, Dr. Raina Lasse, ND 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 Dr. Raina Lasse, ND.

Please mail the records to:
Dr. Raina Lasse, ND
1830 NE Grand Ave.
Portland, OR 97212
Or Fax my information to:
844-685-0297

-ATTENTION-

If document is more than **10 pages**, **PLEASE DO NOT FAX**. ***Mail*** document instead.
Thank you

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
_____Pathology reports
_____Operative report
_____Progress Notes
_____Laboratory report
_____EKG
_____Diagnostic Imaging 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 Dr. Raina Lasse, ND 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)