Dramov Naturopathic Medical Center - Oregon

18861 SW MARTINAZZI AVE, #215 TUALATIN, OR 97062
503-639-6454 FAX 877-365-3958

AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization

I ________________________________, ______________________, __________________ authorize
(name of patient) (Date of Birth) (Social Security#)

______________________________, ________________________, ____________________
(Name of hospital/health care provider) (Phone number) (Fax number)

to release a copy of medical information to:

Dr. Rob Dramov, ND
18861 SW MARTINAZZI AVE, #215
TUALATIN, OR 97062
Phone: 503-639-6454 / Fax: 877-365-3958

This information will be used on my behalf for the following purposes: __________________________

I hereby release the following medical records:

___ Please send entire medical records
___ All hospital records
___ Medical records necessary for continuity of care
___ Laboratory reports/results
___ Other:_______________
___ Diagnostic imaging reports
___ Most recent five year history
___ Pathology reports
___ Clinician office chart notes

The following require the initials of the patient to be released:

___ HIV/AIDS related records
___ Genetic testing information
___ Mental health information
___ Drug/Alcohol diagnosis, treatment or referral information

This authorization is limited to:
Following treatments: ________________ Following time period:___________________

*************Please call us ahead of time if fax is more than 30 pages. Thank you*************

Right to terminate or revoke authorization: *this authorization may be revoked at any time in writing. 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.*
Potential for re-disclosure: *information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.*
Rights of the individual: *you may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization.*

Name of Patient: ____

Signature: ____ **Date:** _______________
(Signature of patient or legal guardian)

Relationship of Representative to Patient: ____