Authorization to Release Medical Records **from** Susana Watson, ND *By law, this Authorization must be written, dated, and signed by the patient in order to release records.*

Patient Name _____ Home Phone Number _____

Date of Birth _____ Work Phone Number _____

I Hereby authorize:	*To send my medical records to:*
Name of person to authorize release of information: **Dr Susana Watson**	**Name of person to receive information:**
Name of clinic/hospital/agency: **Dr Susana Watson, LLC**	**Name of clinic/hospital/agency:**
Street address: **14523 Westlake Drive, Ste 8**	**Street address:**
City, State, Zip code: **Lake Oswego, OR 97035**	**City, State, Zip code:**
Phone and Fax numbers: **Ph: (503) 919-7575** **Fax: (503) 607-8661**	**Phone and Fax numbers:** **Ph:** **Fax:**

By **initialing** the spaces below, I authorize the release of the following medical records, if such records exist:

___ Chart notes ___ EKG ___ Laboratory/Pathology reports
___ Imaging ___ Operative reports ___Other _____
___ Entire medical record (The recipient understands there may be a fee for voluminous records and agrees to pay any charges associated with sending)

Indicate specific dates of service or range (example: last 6 months):_____

The following items must be initialed to be included in other documents:

___ Mental Health records ___ Drug/ Alcohol diagnosis, treatment or referral information
___ Genetic testing information ___ HIV/AIDS related records additional patient signature required:_____

(Federal regulations require a description of how much information and what kind of information is to be disclosed.)
Describe: _____

As required by Privacy Regulations, Dr Susana Watson may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I understand the purpose of this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implication of their release.
This request is entirely voluntary on my part. I am aware that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 180 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____

Signature of Patient or legal guardian **Date**