Release of Medical Records

I ________________________ give permission to release my medical records **TO**

Wendy Schilling, MD
Direct Primary Care
1801 Hwy 99 N, Suite 2
Ashland, OR 97520
P 541.482.6867 F 888.724.9575

FROM: Clinic name: ____

Address: ____

Phone/Fax: ____

Patient Name: ______________________________ Date of Birth: _______________

The type of information to be disclosed:

__ Most recent 3 years of chart notes including lab, radiology

__ Entire medical record

__ Specific lab/pathology reports ____

__ Specific radiology reports ____

__ Hospital reports ____

__ Other ____

Unless specifically excluded below, this authorization includes release of specifically protected information, including referral, diagnosis and treatment information related to: (Please circle all that apply to EXCLUDE the information): Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

I understand that this authorization will expire 1 year from the date of signing or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that records will be sent within 30 days of receipt of this request. I may be charged a reasonable fee for copying records and postage but that may be waived when records are sent directly to another medical office.

Patient signature: _____________________________ Date ___________________________

Patient's parent/guardian/representative ____

Relationship to Patient ___________________________