NW HEADACHE AND WELLNESS CENTER
11782 SW BARNES RD BLDG C SUITE 130
PORTLAND OREGON 97225
Phone: 503-601-0300 | Fax: 503-597-6005

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

PATIENT NAME:_____ DATE:_____
(PLEASE PRINT)
PHONE NUMBER:_____ DATE OF BIRTH:_____

The purpose of the Use/Disclosure is for:
☐ Continuity ☐ Transfer of Care ☐ Personal ☐ Disability ☐ Insurance ☐ Legal ☐ Other

NEEDED BY DATE: ____/____/____

(Circle TO or FROM to indicate where you want records sent)

I Authorize records to be released TO/FROM:	**My Records Are to be sent FROM/TO:**
Dale Carter, MD **Facility Name and/or Physician Name/Title Facility**	_____ **Name and/or Physician Name/Title Facility**
11782 SW Barnes Rd, Building C, Suite 130 **Address**	_____ **Address**
Portland, OR 97225 **City, State, Zip Code**	_____ **City, State, Zip Code**
503-601-0300 503-597-6005 **Phone #** **Fax #**	_____ _____ **Phone #** **Fax #**

INFORMATION TO BE RELEASED:

*(PLEASE **INITIAL** EACH LINE THAT APPLIES -no checkmarks please!)*

_____ Progress/OV Notes (most recent visit)

_____ Progress/OV Notes (last 2 years)

_____ Most Recent Lab Reports (within 3 months) & diagnostic/neuro testing

_____ Any CT, MRI/MRA, MRV, EMG, or other

_____ Current List of Medications w/doses

_____ Other:_____

Protected or Sensitive Information:

Additional federal and state laws protect your rights by requiring specific authorization for the release of the following protected health information. I understand and agree that this information will be disclosed if I place my **INITIALS** in the applicable space next to the type of information:

_____HIV/AIDS information _____Mental Health information
_____Genetics Testing information _____Drug/Alcohol diagnosis, treatment or referral information

PERMISSION TO FAX PROTECTED HEALTH INFORMATION FROM MY MEDICAL RECORD

_____ YES _____ NO My INITIALS give specific consent to fax my information from my medical record. I understand a confidentially statement is included on the fax cover sheet but cannot guarantee the confidential transmitting of my protected health information.

_____ _____ **EXPIRATION DATE:** _____
Patient or responsible Party Signature **Date** **(1 YEAR if not noted otherwise)**