

Southern Oregon Internal Medicine
2900 Doctors Park Drive, Suite 200
Medford, OR 97504



Authorization to Release Medical Information

Patient: _____ Date of Birth: _____

I consent to the release of Medical Information (records):

To: _____ **From: (Physician, Clinic, or Person)** _____

Dr. Noriecel D. Mendoza
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2200
Fax: (541) 282-2274

****PLEASE SEND RECORDS ON CD IF POSSIBLE****

Information to be released:

- _____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. **From Date:** _____ **To Date:** _____
- _____ X-ray reports only. **Date(s):** _____
- _____ Laboratory and Pathology reports only. **Date(s):** _____
- _____ Other tests or studies (list type of test/study and date performed): _____
- _____ Other (specify): _____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. * (Initial if release is authorized)

- _____ Drug and alcohol abuse
- _____ Information related to diagnosis/treatment of HIV.

Please note that a separate release is required for Behavioral Health Information.

Purpose of Disclosure:

This authorization is **valid for six months** after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

Signature of patient or legally authorized representative

Date