

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



Authorization to Release Medical Information

Patient: _____ Birthdate: _____

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

To: (Physician, Clinic, or Person)

From: (Physician, Clinic, or Person)

Dr. Philipp Olshausen

Southern Oregon Internal Medicine
2900 Doctors Park Drive, Suite 200
Medford, OR 97501
Phone: 541-282-2200
Fax: 541-282-2263

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:

****There will be a charge of \$25.00 for the first 10 pages and .25 for each page over this.**

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