AUTHORIZATION TO RELEASE HEALTH INFORMATION

Records to be released from:

Name ....

Address ....

Phone/Fax ....

I hereby request and authorize you to send my medical records, as specified below, to:

Dr. Leigh Saint-Louis, MD
492 East 13th Avenue, Suite 205
Eugene, Oregon 97401
Phone/Fax: 866-581-5559

My name: .... My date of birth: ....

My address: ....

My telephone number: .... My Social Security number: ....

Please release the following information for date range .... to .... :

___Outpatient/ Primary Physician Notes
___Hospital Admission History & Physical
___Hospital Discharge Summary
___Hospital Progress Notes
___Operative Reports
___Consultant Reports/Correspondence
___Lab Reports
___Pathology Reports
___X-ray Reports
___Therapy Notes
___Special Test Results:
....
___Other:
....

Unless limited below, I understand this release may include medical records concerning evaluation, hospitalization, or treatment for conditions including but not limited to alcohol or substance abuse, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted disease (STD), or psychiatric conditions.

Limitations, if any:

___ Please release only summary information from records regarding the following condition/s: ....

....

___ Please release only the following specific information: ....

....

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED.

Signature: .... Date: ....

___ Parent/Guardian (Relationship to Patient: ....)

___Witness, Patient unable to sign (Reason:..)