Kwan-Yin Healing Arts Center, Inc.

3115 NE Sandy Blvd. Suite 231 Portland, OR 97232
2330 NW Flanders St. Suite 101 Portland, OR 97210
Phone: 503-701-8766 Fax: E 971-255-0727 W 503-241-5484

MEDICAL RECORDS RELEASE FORM

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

Patient Legal Name: _____ **Date of Birth:** _____

I authorize Kwan-Yin Healing Arts Center to:

☐ **Obtain** ☐ **Release** ☐ **Verbal & Written Communication** the information as indicated below:

Name of person, Clinic and/or Agency:_____

Mailing Address: _____

Telephone:_____ Fax: _____

****** please call before faxing any records over 100 pages******

By **initialing** the spaces below, I authorize the above provider/clinic/hospital to release written records pertaining to thefollowing information. I also authorize the above provider/clinic/hospital to provide the following information via telephone consultation:

_____ All Medical Records *(for the past 1 year)*
_____ Laboratory Tests *(for the past 2 years)*
_____ Pathology Reports *(for the past 5 years)*
_____ Diagnostic Imaging Reports *(for the past 5 years)*
_____ Chart Notes Only *(for the past year)*
_____ Other:_____

Protected or Sensitive Information. I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. Please initial below if you agree to release the following information:

_____ I recognize that the information disclosed may contain Drug/Alcohol information that is protected by federal and state law. I specifically consent to disclose such information.

_____ I recognize that the information disclosed may contain Mental Health information that is protected by federal and state law. I specifically consent to disclose such information.

_____ I recognize that the information disclosed may contain HIV/AIDS testing and related information, including high risk behavior documentation. I specifically consent to disclose such information.

_____ I recognize that the information disclosed may contain Genetic Information (including Genetic Test Results) testing and related information, including high risk behavior documentation. I specifically consent to disclose such information.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Guardian/Guarantor	Signature of Guardian/Guarantor	Date

Office Use Only: Date Sent_____ **Provider:**_____ **Initials:**_____