# Kwan-Yin Healing Arts Center

**2330 NW Flanders St. Ste. 101, Portland, OR 97210**
**Phone: 503-701-8766 Fax: 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 Name:**_____ **Date of Birth:** ____/____/____

I authorize Kwan-Yin Healing Arts Center ☐ **To Obtain and/or** ☐ **To Release** 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.

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

Office Use Only: Date Sent_____ Provider:_____ Intitals:_____