

AUTHORIZATION TO RELEASE HEALTH INFORMATION

My [Patient's] name:
My [Patient's] date of birth:
My [Patient's] complete address:
My [Patient's] complete telephone number/s:

Please send my medical records, as specified below, to:
Dr. Leigh Saint-Louis, MD
Board Certified Family Physician
3575 Donald Street, Suite 230
Eugene, Oregon 97405
Fax: 866-581-5559

Records are to be released from my previous care provider:

Name
Address
Phone/Fax

Please release the following information for date range to

- | | |
|---|---|
| <input type="checkbox"/> Primary Physician/ Outpatient Clinic Notes | <input type="checkbox"/> Consultant Reports/Correspondence |
| <input type="checkbox"/> Immunization Records, Outpatient/ Hospital | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Hospital Admission History & Physical | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Imaging Reports (XR, MRI, CT, U/S, etc.) |
| <input type="checkbox"/> Hospital Progress Notes | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Special Test Results: |

- Purpose of requested information:
- | | |
|--|--|
| <input type="checkbox"/> Continuity of care with new physician | <input type="checkbox"/> Insurance issue |
| <input type="checkbox"/> Out of town move | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Legal/ disability case | <input type="checkbox"/> 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, BY MAKING A WRITTEN REQUEST TO DR. LEIGH SAINT-LOUIS, MD. THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS FROM THE DATE SIGNED.

Signature: Date:
___ Parent/Guardian (Relationship to Patient:)
___ Witness (Patient unable to sign; reason:.....)