Salem Naturopathic Clinic, P.C.
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

Dr. Donald D. McBride
Dr. Esther Y. Tak

MEDICAL RECORDS RELEASE REQUEST

Patient Name: ______________________________________ Date of Birth: ________________

Initial	PLEASE INITIAL BY THE LINE(S) THAT APPLY TO YOUR REQUEST:
	Health care information relating to the following treatment, condition, or date of service:
	The following specific information (please circle): Chart Notes Lab / Pathology Reports Imaging / X-Ray Reports Actual Imaging Films EKG / Cardiac Studies Other Information:
	All health care information.
	I understand that my express consent is required to release health care information relating to: Testing, diagnosis and/or treatment of HIV, sexually transmitted diseases, psychiatric disorders, mental health status, or drug and/or alcohol use. If I have been tested, diagnosed and/or treated for any of the named conditions, <u>you are specifically authorized to release all information relating to such diagnosis, testing and/or treatment.</u>

<u>Clinic/Physician to receive records:</u> (*Please select*)

a)___
Salem Naturopathic Clinic
1305 Broadway Str. NE
Salem, OR 97301
P. 503-364-1441
F. 503-364-9924

b)___
Physician's Name: ____
Clinic Name: ____
Street Address:____
City, State, Zip: ____
Phone: _____________________ Fax: _________________________

By signing this form I request and authorize you to release my confidential health information to the clinic/physician listed above.

____ ______________________
Signature of patient or guardian Date

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER THE DATE SIGNED