Dr. Jennifer O'Leary, ND
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# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____
Previous Name_____
Date of Birth_____ SSN_____ Phone_____

I authorize release of information from:

Name of physician or facility_____
Street Address_____
City, State, Zip_____

To: Jennifer O'Leary, ND 15645 SE 114th Ave, Clackamas, OR 97015

1. I understand that my records are protected under state and federal confidentiality laws and that my written consent is required for their release. I authorize the above named facility to release the following information, via written or verbal communication.

_____All medical records including x-ray and lab reports
_____Only medical records from (date)_____to (date)_____
_____Only medical records pertaining to _____
_____Only lab reports from (date)_____ to (date)_____

Signature of patient or legal guardian _____ Date_____

2. I specifically authorize release of the following information:

_____Alcohol and drug treatment information
_____Mental health treatment information
_____Sexually transmitted disease release information
_____HIV/AIDA testing information/results

Signature of patient or legal guardian_____ Date_____

3. I specifically consent to the transmission of my medical records by a fax machine.

Signature of patient or legal guardian_____ Date_____
Consent may be revoked at any time. The only exception is when the action has already occurred as instructed in this consent.