MEDICAL RECORDS RELEASE REQUEST

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Name of Health Care Provider/Medical Office/Hospital **FROM** which you are requesting medical information

________________________________	____________	_____	__________________
Address	City	State	Zip Code
________________	_________________		
Telephone	Fax		

I hereby authorize _____________________ *(your physician)* to release and/or disclose the medical information as indicated below to:

Arnaud Versluys, PhD, LAc

Kindly forward as soon as possible:

All Medical Records Labs & Diagnostic Imaging Only Other ______________

To: **Acupuncture Associates of Oregon LLC**
Address: **2335 NW Raleigh Street, Ste 123, Portland, OR 97210**
Fax: **503-227 1089**
Email: **aversluys@aaofo.com**

Regarding: ___________________________________	______________	__________________
Name of Patient	Date of Birth	Telephone Number

________________________________	____________	_____	__________________
Address	City	State	Zip Code

This authorization shall become effective immediately and shall remain in effect until ________________
(Enter date)

Or for one year from the date of signature if no date is entered. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

__________	____	________________
Date	Signature of Patient or Patient's Representative	Relationship *(If signed by Representative)*

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