Acupuncture Associates of Oregon LLC
2335 NW Raleigh Street, Ste 123
Portland, OR, 97210

Arnaud Versluys, PhD, LAc
Patient Information Form 6
Medical Records Release

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____ *(your name)*, authorize **Arnaud Versluys, PhD, LAc** of Acupuncture Associates of Oregon LLC, to release and/or disclose all relevant medical information as specified below:

_____	_____	_____	_____
Your Address	City	State	Zip Code

_____	_____	_____
Date of Birth	Telephone Number	Email address

Kindly forward as soon as possible:

☐ All Medical Records ☐ Prescriptions Only ☐ Other_____

TO:

_____
Name of Health Care Provider/Medical Office/Hospital **TO** whom you are releasing medical information

_____	_____	_____	_____
Address	City	State	Zip Code

_____	_____
Telephone	Fax

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)*