MT SCOTT
EAR, NOSE AND THROAT, & SLEEP MEDICINE

9280 SE Sunnybrook Blvd # 300, Clackamas, OR 97015
telephone 503.233.5548, *facsimile* 503.230.1009
www.mtscottent.com

Aleen Lee, MD
Haena Kim, MD
James Chan, MD

John Richards II, MD
Kathleen Theilacker, AUD
Valerie Ing, DO

RELEASE OF MEDICAL INFORMATION

I,____, hereby authorize __________________________
(Patient)
____

To release copies of medical records and other information concerning my diagnosis and treatment, including but not limited to information concerning treatment of drug or alcohol abuse, alcoholism, drug related conditions HIV testing or treatment of HIV related conditions, psychiatric/psychological conditions. Review of records is also authorized.

The following information may be released or reviewed:

- ( ) Case Summary
- ( ) Doctors Orders and Progress Notes
- ( ) Immunization Records
- ( ) History and Physical Exam
- ( ) Other ____

( ) Lab Work
( ) X-ray Reports & Other Testing
( ) Chart problem list
( ) Consultations

Purpose For Disclosure: **On Going Medical Care**

The above information is to be released to: _________________________________.

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty 3 years after the date below, or sooner by choice, in which case this consent will expire on: ___________________________.

____
Patient's Name

____
Signature of Patient

____
Today's Date

____
Other person legally authorized to give consent

____
Birth Date

____
Relationship to patient and reason

This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by Federal Law.