MEDICAL RECORDS RELEASE REQUEST

_____

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: (please circle as appropriate)

Arnaud Versluys, PhD, LAc and/or Kumiko Shirai, MSOM, LAc

Kindly forward as soon as possible:

☐ All Medical Records ☐ Labs & Diagnostic Imaging Only ☐ Other _____

To: **Acupuncture Associates of Oregon LLC**
Address: **3**024 SE 59th Ave, Portland, OR 97206
Fax: **(503) 841-5781**
Email: **info@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)*