# MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____ *(your name)*, authorize Arnaud Versluys, PhD, LAc and/or Kumiko Shirai, MSOM, LAc (circle as appropriate) 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)* |