Please complete this form in its entirety. Items not initialed or unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. The patient may revoke this authorization at any time.

Patient Name (Print):_____
DOB:_____Telephone:_____
Address:_____

I hereby authorize Ann Childers, MD, 543 Third st ste A-2 Lake Oswego, OR 97045. Phone# 503-344-6211. Fax# 503-344-6991 to (Initial):

_____Disclose Records
_____Receive Records

Name of person/ facility to receive/ disclose to:_____
Address (City/ State/ Zip code):
_____
Telephone and Fax Number: _____

Covering the periods of healthcare (Date(s) of Service):
From (date):_____ To (date): _____
For the purpose of: _____

Information to be released (Initial all that apply)

- □ **_____Lab Results**
- □ **_____General medical record**
- □ **_____AIDS/ related illness, diagnosis/ treatment HIV results**
- □ **_____Behavioral Health service/ psychiatric care**
- □ **_____Treatment for alcohol and/ or drug abuse**
- □ **_____Genetic Testing**
- □ **_____Other (please specify):_____**

Affirmation of Release

I give Dr. Ann Childers permission to release only the information I have selected on this form to the individual(s) or providers(s) I have named and only for the purposes I have checked. I understand that this release is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health are clearinghouse covered by the federal privacy regulations or a business associate of the entities, the information described above may be redisclosed and no longer protected by the regulations.

Expiration Date:_____
Signature of Patient/ Representative Relationship:

_____Date signed:_____