Sara Ohgushi, N.D.
2207 NE Broadway, Suite 200, Portland, OR 97232
Phone 503-236-6006 FAX 503-232-3436

Request and Authorization to Release Medical Information

I: _____ **Authorize:** _____
Patient's name — Name of health care provider or hospital

_____ _____
Social Security # DOB — Address

_____ _____
Address Phone — City State Zip code

_____ _____
City State Zip code — Phone #

_____
Fax #

to release a copy of my medical information to:

Sara Ohgushi, N.D.
2207 NE Broadway, Suite 200
Portland, OR 97232

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

___ Health records including chart notes: ___ all dates OR since _____(date)

___ Lab results

___ Imaging reports

___ HIV/AIDS related records (must be initialed to be included with other documents)

___ Mental Health records (must be initialed to be included with other documents)

I understand that this authorization is valid for SIX months from the date of signing unless revoked in writing earlier. The only exception is when the action has already occurred as instructed in the consent.

X _____ _____ _____
Signature of patient or person authorized by law — Date — Relationship to Patient