



Liz Wallace, ND, LAc, MSOM

Naturopathic Physician • Liscensed Acupunturist

## Request And Authorization to Release Medical Information

<b>I hereby authorize:</b> <hr/> Name of person authorized to release information <hr/> Name of Clinic/Hospital/Agency <hr/> Street Address <hr/> City State Zip Code <hr/> <b>TELEPHONE</b> <b>FAX</b>	<b>To send my medical records to:</b>  Elizabeth Wallace, N.D. LAc 2024 SE Clinton Street Portland, OR 97202 VOICE: 503- 242-1212
<b>Patient Information</b> <hr/> Patient's Name Date of Birth <hr/> Social Security Number Phone Number <hr/> Street Address <hr/> City State Zip Code	By indicating below, I authorize the release of the following specific confidential information:  <input type="checkbox"/> <b>Health Records</b> (please specify) _____  <input type="checkbox"/> <b>Lab Results</b> <input type="checkbox"/> <b>X-ray reports</b> <input type="checkbox"/> <b>X-rays</b> <input type="checkbox"/> <b>Other</b> _____ _____



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*I hereby consent to release the above information, including alcohol, drug abuse, and mental health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency. I further 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.*

<b>Signature (patient, guardian, legal representative)</b>	<b>Date</b>	<b>Relationship to patient</b>

**Specifically Protected Information**

I understand that a variety of tests have been undertaken and one of them may have been an HIV-related test. My signature below authorizes release of any test results including any HIV-related (AIDS) test results.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_