mississippi health center

4631 N. Albina Portland, OR 97217 (503) 282-5358 FAX: (503) 546-0033

Authorization For The Release of Medical Records

Patient's Name (Please Print) Date of Birth	
I authorize the above physician to release Health Center, attn Dr. Justin Ilsley or Be	,
Patient/Guardian Signature	Date
""" The following information is being request Clinic Visits Laboratory results Medical procedures	
	rom the date of signed release.
I specifically consent to transmission of Medical records via fax machine to fax #503-546-0033	I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law. I specifically consent to the disclosure of such information.
Signature/Date	
I recognize that the information disclosed may contain mental health information that is protected by federal and state law. I specifically consent to disclosure of such information. Signature/Date	Signature/ Date I recognize that the information disclosure may contain information regarding sexually transmitted diseases or HIV/ AIDS. I specifically consent to disclosure of this information.
	Signature/ Date