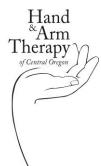


2041 NE Williamson Ct Suite B Bend, OR 97701 Voice 541-633-7535 Fax 541-706-9036

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient:		DOB	
Ad	dress:		
Home Phone:		Cell Phone	
PA [®]	TIENT REQUEST FOR MEDICAL RE	<u>CORD</u>	
0	I hereby request to receive a co	by of my protected health information	
0	I hereby request to receive copi	es of my billing statements	
0		of disclosures of my protected health information made for purposes or health care operations (other than insurance, attorney, or physician)	
AU	THORIZATION OF RELEASE OF M	DICAL RECORDS	
0	I hereby authorize Hand & Arm Therapy of Central Oregon to use and disclose specific health and medical information about me to the following third party:		
Na	me:		
Ad	dress:		
For	the following purpose:		
Inf	ormation to be disclosed to this th	ird party:	
	o My entire medical record		
		nal therapy referral, diagnosis & treatment	
	 Only billing statements 		
	 Only the following specific its 	m(s):	
sub "No disc	oject to re-disclosure by the recipient otice of Privacy Practices" for Hand o closes information. I also understa	I that the information used or disclosed pursuant to this authorization may be and may no longer be protected under applicable federal law. I have read the Arm Therapy of Central Oregon and understand how this clinic uses and I may revoke a request for disclosure in writing at any time, however any mission cannot be taken back.	
Pat	ient Signature:	Date:	



2041 NE Williamson Ct Suite B Bend, OR 97701 Voice 541-633-7535 Fax 541-706-9036

`	
ORPatient Representative:	Date: