**Serenity Wellness Clinic, LLC**
**8555 SW Tualatin Road, Suite B**
**Tualatin, Oregon, US - 97062**

# Medical Records Release Form (Rev0121)

*This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received. This clinic is not authorized to share records generated by other providers or clinics.*

Patient Name *

Date of Birth *

This request authorizes Dr. Bijana Kadakia, ND, LAc of Serenity Wellness Clinic, LLC to either obtain or release records as follows: *

- ☐ Obtain records from another provider or clinic
- ☐ Release records to another provider or clinic
- ☐ Discuss my healthcare with or in front of a family member or other authorized person
- ☐ Discuss my billing, but not my healthcare details with or in front of a family member or other authorized person

Name of person, clinic or agency *

Mailing address. Please provide the complete mailing address if possible. If not, please provide an approximate location. *

Phone number *

By indicating an option below and initialing, I authorize the above provider/clinic/hospital to release written records pertaining to the following information. I also authorize the above provider/clinic/hospital to provide the following information to Dr. Kadakia via telephone consultation.

I authorize the disclosure of the following information: *

- ☐ Laboratory Tests (for the past 2 years)
- ☐ Chart Notes Only (for the past 1 year)
- ☐ All Medical Records (for the past 1 year)
- ☐ Diagnostic Imaging Reports (for the past 5 years)
- ☐ Pathology Reports (for the past 5 years)
- ☐ Disclosure to a family member or other authorized person as described above

Please initial to indicate that you wish to share per the selected option above.

**Protected or Sensitive Information.**

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. Please initial below if you agree to release the following information:

*specifically consent to disclose such information.*

Please initial here to indicate your consent
to share the above described information: _____

*I recognize that the information disclosed may contain Mental Health information that is protected by federal and state law. I specifically consent to disclose such information.*

Please initial here to indicate your consent
to share the above described information: _____

*I recognize that the information disclosed may contain HIV/AIDS testing and related information, including high risk behavior documentation. I specifically consent to disclose such information.*

Please initial here to indicate your consent
to share the above described information: _____

**SIGNATURE**

**PATIENT SIGNATURE** * _____

Date * _____

If signed by someone other than the patient, please sign and indicate relationship. Verification that you are legally authorized to sign on the patient's behalf may be required.