



## AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I, the above named person, request:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

To release my health care information to:

Name: **Center for Integrative Health and Performance**

Address: **132 E. Broadway, Suite 332**

City: **Eugene** State: **Oregon** Zip Code: **97405**

This request and authorization applies to:

Health care information relating to the following treatment, condition and/or dates:

\_\_\_\_\_

All health care information

Other: \_\_\_\_\_

**This release expires 60 days after date signed**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_