NW Family Wellness Center
10365 SE Sunnyside Rd. Suite 210
Clackamas, OR 97015
P: 503.887.7725 F: 503.855.3269

Release of Medical Records to NW Family Wellness Center

Medical Authorization to Disclose Personal Medical Information

I, _____, DOB:_____, authorize

☐Mary T. Coleman, DC ☐Amy Stell, LAc ☐Josephine Munoz, LMT ☐Other (list below)

_____ to disclose my health

information as identified below to: _____

By initialing below, I specifically authorize disclosure of the following health information and records:

_____ Entire Medical Record (chart notes, x-ray reports, etc.)_____

_____ Only the following files in my Medical Record _____

_____ Billing Record _____

_____ Other _____

If information to be disclosed contains any of the following types of information or records listed below, additional laws relating to disclosures of this information may apply. The following categories must be initialed to be included in the authorization to release information.

_____ ***HIV/AIDS related information records

_____ ***Mental Health information records

_____ *** Genetic Testing information records

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.

Signed:_____ Date:_____

Please Print Name:_____