15962 SW Boones Ferry Rd #102, Lake Oswego, OR 97035
Phone: 503-655-9493 Fax: 503-699-1847

Laurie Marzell, N.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security Ending (Last 4) #: ______________________

I request and authorize ____
(name of doctor to release records)

*Doctor Phone number: ______________________ *Doctor Fax Number: ______________________

Doctor Specialty: ______________________ to release healthcare information of the patient named above to:

Name: Laurie Marzell, N.D.

Address: 15962 SW Boones Ferry Rd #102

City: Lake Oswego State: OR Zip Code: 97035

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ Chart Notes ☐ Most recent labs ☐ Radiology/Xray (Report Only)

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.