PDX ENT & Audiology
2222 NW Lovejoy St Suite 607
Portland, Oregon 97210
Phone: 503-222-3638 | Fax: 503-223-5139

Permission to Release Medical Records

1. Patient's Name: _____
2. Date of Birth: _____ Today's Date: _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

FROM: Provider: ____PDXENT & Audiology Medical Group PC_____
Address: __2222 NW Lovejoy Ste 607 Portland, OR 97210_____
Address: __9155 SW Barnes RD Ste 208 Portland, OR 97225_____
Phone: _503-222-3638_____ Fax: _503-223-5139_____

TO: Name: _____
Address: _____
Phone: _____ Fax: _____

3. The following information may be released:

☐ All records	☐ Abstract of medical summary	☐ X-ray reports/films
☐ Hospital Summary	☐ Chart notes	☐ CT reports/films
☐ Electrocardiogram	☐ Immunizations	☐ Audiogram
☐ Laboratory data	☐ Sleep study report	☐ NCV

4. The following date of service: From: _____Through: _____
5. I consent to the transmission of my medical records via a facsimile (fax) machine.
6. **SIGNATURE:** _____ **DATE:** _____

I recognize that the information disclosed may contain mental health, drug, or alcohol information that is protected by federal and state law. I specifically consent to release of such information.

_____ _____
(Signature) (Date)

I recognize that the information disclosed may contain information regarding sexually transmitted disease or HIV/AIDS Tests. I specifically consent to disclosure of such information.

_____ _____
(Signature) (Date)