



Authorization to Release Medical Records

This is a request to obtain a copy of your medical records.

Patient Name: _____ Date of Birth: _____

Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

I hereby authorize the release of my healthcare information to be **mailed or faxed to** Curtis Kunkel, ND at this address:

Rogue Natural Medicine
6318 SE 87th Ave
Portland, OR 97266
Phone: (541) 727-1893
Fax: (541) 727-6001

From the following provider:

Physician Name: _____

Clinic Name: _____

Address: _____

Phone: _____

By marking the appropriate spaces below, I authorize the release of the following records:

_____ Lab/Pathology reports from _____ to _____

_____ Imaging reports from _____ to _____

_____ Clinical records from _____ to _____

_____ Other - Please be specific _____

- This authorization will expire 180 days from the date of signing.
- Rogue Natural Medicine may not use or disclose your protected health information except as legally required by law without your authorization.
- I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond the control of Rogue Natural Medicine.
- I understand that I may revoke this authorization at any time by sending written notice to Rogue Natural Medicine at the address above.
- I also understand that I may refuse to authorize the release of any or all of my health information by not signing this authorization. However, by doing so, I may hinder the quality of care that my medical provider is capable of rendering to me.

*Signature of Patient or Patient's Authorized Representative (Relationship)

Today's Date