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
PO Box 1052
Klamath Falls, OR 97601
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