Integrative Family Medicine of Bend

Authorization for Release of Medical Records For Personal Use Only

Patient Full Name : Date of Birth

Address City State Zipcode

I herby authorize Integrative Family Medicine of Bend to release the following records:

- ☐ Laboratory Reports
- ☐ Radiology Report
- ☐ Other

Information Release to: Self-Personal

Purpose of Disclosure: Personal

I understand the information used or disclosed is for my personal use and understand and accept the statements contained in this authorization. I also understand if I wish to request to have any of my medical records to be released to another physician or entity, a different Medical Records release has to be obtained, reviewed, and signed. This authorization may be revoked at any time **unless revoked early this authorization will expire** one **year from the date of original signing.**

Signature of Patient or Personal Representative Date Date

Doctor Signature of Approval Date