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2701 NW Vaughn St, Suite 424
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Medical Records Release

I, ________________________________ (DOB_____/_____/_____) authorize the release of my personal medical information listed below.

Please release/disclose the following information:

- □ Chart Notes
- □ X-Ray film or disc (please send in mail)
- □ X-Ray Report
- □ MRI disc (please send in mail)
- □ MRI Report
- □ Lab Work and Results
- □ Surgical Reports
- □ Pharmacy/Prescription Records
- □ ______________________

Records being requested:

To/From

Northwest Foot and Ankle
2701 NW Vaughn, Ste 424
Portland, OR 97210
Phone: 503.243.2699
Fax: 503.243.2698

To/From:

____
____
____

Phone #:______________________

Fax #:________________________

Patient
Signature______________________________________Date_______________

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