



Dr. Travis J. Elliott

NATUROPATHIC PHYSICIAN

Authorization to Release Medical Information

I understand that my records are protected under state and federal confidentiality laws and require written consent for release. I authorize release of medical records as follows:

Name: _____
Please Print Clearly

Date of Birth: _____

Permission is hereby granted for release of information

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Portland, Oregon 97219
Phone 503-206-7773
Fax (866) 202-3703

TO OR FROM
(please circle one)

FROM OR TO
(please circle one)

Name of Physician

Name of Clinic

Address

City, State, Zip

Phone

Fax

Chart notes
 Diagnostic records – laboratory tests and Imaging reports
 other records: _____

For past 1 year / 2 years / other time (circle one): _____

Drug & Alcohol Treatment Mental Health Treatment

HIV Status & Treatment Genetic Testing

Signature of Patient or Representative

Date:

Relationship (if signed by a representative)

Representative phone number