Medical Records Release Form

By signing this form, I authorize _____ to release confidential health information and medical records to:

Heather Krantz, M.D.
PO Box 6913 Phone: 541-241-2226
Bend, OR 97708

Patient Name:_____Date of Birth:_____
Alternate name(s):_____
Phone:_____

Please release information only about the following problems:_____
_____
_____

This information may include:

- ☐ History & Physical
- ☐ Progress Notes/Treatment Records
- ☐ Lab Reports
- ☐ HIV Testing/Treatment
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Hospital Records
- ☐ Other_____

This release will be valid for one year from the date signed unless otherwise specified.

_____

_____
Signature of Patient or Authorized Representative

_____ _____
Patient Name (printed) Guardian Name (printed) *(if applicable)*

_____ _____
Date Relationship