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CONSULTATION
MEDICAL RECORDS RELEASE

Please complete this form and bring to your appointment. Medical records may be requested by the physician after your appointment.

Please print

To be released from:

Provider Name		Provider Name	
Phone		Phone	
Fax		Fax	

Please release the complete medical history and records in your possession for:

Patient Name		DOB		SSN	

PSYCHIATRIC, HIV, DRUG and SUBSTANCE ABUSE information to be included unless checked: ☐

This consent may be revoked by the signed at any time except to the extent that release information has already occurred. Unless otherwise noted, this consent will expire in 90 days.

Signed		Date	

Please send records to:

Miles Hassell, MD
Providence St. Vincent Medical Center
9155 SW Barnes Rd., Suite 302
Portland, OR 97225

please mail large volume records - do not fax