AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME _____

BIRTHDATE_____

I/WE HEREBY AUTHORIZE _____
NAME/INSTITUTION
_____
STREET ADDRESS
_____
CITY / STATE / ZIP
_____
TELEPHONE NUMBER
_____
FAX NUMBER

AND

LAKE OSWEGO PSYCHIATRIC ASSOCIATES
ALLEN L. STARK M.D.
CAROL L.R. STARK M.D.
4000 Kruse Way Place, Bldg 2, Suite 200
Lake Oswego, OR 97035
503.635.9336 PHONE 503.635.5414 FAX

to exchange any information, medical, psychological, scholastic, social which may pertain to my/ our child _____ or myself. The question of privacy between the above named parties and the patient is waived. This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above mentioned. I specifically authorize the release of information pertaining to psychological and/or psychiatric impairments, drug and/or alcohol abuse, if such is a part of my records. You are hereby released from all legal liability that may arise from the release of the information requested.

By initialing the spaces below, you state that you understand and agree that the following health information may be disclosed.

___ HISTORY & EVALUATION
___ MEDICATION MANAGEMENT
___ PROGRESS NOTES
___ TEST RESULTS/CONSULTATION
___ AIDS RECORDS OR HIV TESTING
___ GENETIC TESTING
___ OTHER _____

This release expires 12 months from date of signature. It may be revoked with written notification at any time except to the extent that action has been taken in reliance on the consent.

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF PATIENT / GUARDIAN

_____ _____
DATE SIGNATURE OF PARENT / GUARDIAN