



Raina Monet Lasse

LISTEN. UNDERSTAND. HEAL.

Release of Records

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

As required by the Privacy Regulations, Dr. Raina Lasse, ND may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: _____

Address: _____

to disclose my patient health information Dr. Raina Lasse, ND.

Please mail the records to:

Dr. Raina Lasse, ND
3423 NE Schuyler Street
Portland, OR 97212

Or Fax my information to:

844-685-0297

-ATTENTION-

If document is more than **10 pages**, **PLEASE DO NOT FAX. Mail** document instead.
Thank you

By initializing the spaces below, I authorize the release of the following records to Red Leaf Natural Health, if such records exist:

- _____ Entire Medical Record
 - _____ Progress Notes
 - _____ Laboratory report
 - _____ Diagnostic Imaging report
- Other, specifically: _____

This authorization will expire in 180 days from the date of signing.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I have read and understand the Notice of Privacy Practices of Dr. Raina Lasse, ND regarding my health information and understand that I have the right to revoke this authorization in writing at any time. I understand that I do not have to sign this authorization and may request a copy of it at any time.

Signature of Patient or Authorized Representative (relationship) Date: _____