MEDERI CENTER

Wholistic Health and Healing
Patient Care | Research | Education

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:

To:

Dear

I hereby authorize and request that you release and deliver or fax to:

Mederi Center
478 Russell Street, Suite 101
Ashland OR 97520

Specifically requested medical records such as: latest laboratory, pathology and imaging reports (no film please). You may bill me for any costs. You are further requested not to disclose any information concerning my past or present medical condition to any other person without my express written permission.

Thank you for your cooperation.

In the presence of:

_____
Witness

_____
Name (Printed)

_____
Date of birth

_____
Signature

_____
Street Address

_____
City, State and Zip