Inkwell Medical Group, LLC
Records Request Form

Patient: _____

Date of Birth: _____ Phone Number:_____

Please send the past 5 years of patient's clinical notes, lab reports, xrays, diagnostic imaging, operative reports.

I authorize the release of my medical records **from**:

Provider name:_____ Clinic Name: _____

Address: _____ Phone: _____

City:_____ State:_____ Zip: _____

To: _____ at Inkwell Medical Group, LLC. 2911 Tennyson Ave,

Ste 201, Eugene, OR 97408. Phone: 541-844-1495. Fax 541-844-1492

Request sent: _____ by: _____

I understand:

The recipient of these records cannot transfer them to another party without consent from me or my authorized representative. This authorization will expire in 60 days and can be revoked at anytime. I agree to release all records for the purpose of my ongoing medical care, and that these records may contain sensitive information including information regarding drug and/or alcohol use, mental health treatment and other issues. I have read the content of this release form and any questions I may have had, have been answered to my satisfaction.

_____ _____

Patient signature/authorized representative Date:

I further authorize that all psychiatric, drug, alcohol, Acquired Immunodeficiency Syndrome (AIDS) or HIV/HTLV test results/records be released to the above. In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the purpose of release of HIV/HTLV test results/records:

_____

_____

HIV /HTLV results may be released from _____ up to and including _____

_____ _____

Patient signature/authorized representative Date: