BEARCREEK
NATUROPATHIC CLINIC LLC

Dr Cory Tichauer and Associates
2612 EAST BARNETT RD., MEDFORD, OR 97504
PH 541.770.5563 FX 541.772.3028
WWW.BEARCREEKCLINIC.COM

Bear Creek Naturopathic Clinic, Ph. 541-770-5563; Fx. 541-772-3028

Authorization to Release Confidential Health Information

Patient Name_____ Date of Birth_____
Address_____ Phone_____
_____
Responsible Party Name_____ Relationship to Patient_____

For the Purpose of: ☐ Concurrent Care ☐ Transfer of Care (Permanent) ☐ Other

I authorize the release of healthcare information:
☐ from ☐ to:

Practice/Provider_____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

Send Information ☐ from ☐ to:

☐ Cory Tichauer, ND
☐ Daniel Smith, ND
☐ Dr. Margaret Philhower, ND
☐ Dr. Tom Messinger, ND, RN
☐ Any/All BCNC Providers
☐ _____

☐Permission to Fax (25 pages max)
☐Permission to send by mail
(Please send by mail if over 25 pages)

I specifically authorize the release of the following medical records, if such records exist (check):

____ Clinician office chart notes
____ Diagnostic imaging films
____ Diagnostic imaging reports
____ Laboratory reports
____ Pathology reports
____ Most recent 5 year history
____ Treatment or referral information
____ Physical therapy records
____ All hospital records
____ Transcribed hospital records
____ Emergency/urgent care records
(initial)____ *Mental health provider information
(initial)____ *HIV/AIDS- related records
(initial)____ *Genetic Information/Testing
(initial)____ **Drug/alcohol diagnosis

***Must be initialed to be included in other documents.**
****Federal Regulation, 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed. _____.**

____ This authorization is limited to the following treatment: _____ .
____ This authorization is limited to the following time period: _____ .
____ This authorization is limited to a workers' compensation claim for injuries of: _____ .

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, **this consent will expire 180 days from the date of signing** or shall remain in effect for the period reasonably needed to complete the request. A copy of this request is acceptable in lieu of the original.

Patient/Responsible Party Signature_____ Date_____