Integrated Joint Specialists DBA Reflex
Four Lincoln Center
10250 SW Greenburg Road Ste. 115
Tigard, OR 97223

Reflex Medical Documents Release Form

State and federal laws recognize the need for written authorization.

All releases based on this form include records leading up to the signed date, as well as all records created at the office of Reflex going forward. This consent form will remain valid for three years following the signed date, unless Reflex receives written notification from the signee to revoke said status.

The purpose of this *Authorization* is to enable the individual(s)/group(s)/practice(s) named above to release, review, and coordinate information regarding my medical care received from Reflex. I understand that once my health related information is released by Reflex, they can no longer guarantee the confidentiality of my information because it is no longer under their control.

There is no fee associated with records released from Reflex.

To obtain a copy of test results, procedures and/or notes that were done at another health care organization, please contact that facility directly. Reflex is not able to request them on your behalf without your previous written consent at that facility.

By signing below, I authorize Reflex to provide medical records/health related information pertaining to my treatment as necessary.

Patient Name | Patient Signature | Date

Patient date of birth | Patient Address

If patient is less than 18 years of age:

Guardian Name | Guardian Signature | Date