

**Nanopractice PDX**  
**3933 NE MLK Jr Blvd Suite 101**  
**Portland OR 97211**  
ph:503.922.3937      fax: 503.200.2300

**AUTHORIZATION TO RELEASE INFORMATION**

Patient's Full Name: \_\_\_\_\_

Former Name if applicable: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone Number : \_\_\_\_\_

I authorize information to be released (circle one)

**TO or FROM**      Nanopractice PDX and Dr. Chrissie Ott  
3933 NE MLK Jr Blvd Suite 101 Portland OR 97211  
ph:503.922.3937      fax: 503.200.2300

**FROM or TO:** (Clinic Name): \_\_\_\_\_

Physician: \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Type of information requested: (circle one)**

**GENERAL** medical records (will be limited to 2 years of information unless otherwise requested) including office visits, vaccinations, growth charts, medications, labs, ekgs, radiology results, etc.

**SPECIFIC** information only. Please indicate requested information: \_\_\_\_\_

**PROTECTED or SENSITIVE** information.

\*Authorize by marking the approved topics:

- alcohol or substance abuse diagnosis/ treatment
- HIV/ AIDS related information including relevant high risk behaviors
- sexually transmitted diseases
- mental health treatment
- genetic testing

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*This authorization is valid for 90 days from the above date and may be revoked by the patient at any time therein*