EDMUND H. TORKELSON, D.O, P.C.
INTERNAL MEDICINE
P.O. BOX 6566
BEAVERTON, OR 97007

Request for Release of Medical Records

Medical Records to be sent **from**:
Edmund H. Torkelson, D.O., P.C.
P.O. Box 6566
Beaverton, OR 97007
Email: records@drtorkelson.com

Records to be released **to**:
_____
_____
_____
_____

Please release complete medical history and records in your possession pertaining to the care of:

Patient name: _____

Address: _____

City, State, Zip: _____

Birth date: _____

Information Requested

___ All Pertinent Records ___Last 2 Years Complete Records __ Specific: _____

Purpose for Release:

___Continuing medical care ___Transfer of Care ___Other: _____

Disclosure of Specially Protected Information

If the information to be disclosed contains any of the types of records/information listed below, additional laws relating to the use and disclosure of the information may apply. This information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS Information ____ Genetic Testing Info ___Mental Health Info

_____ Drug/Substance Abuse Information, treatment, or referral information

This consent may be revoked by the signed at any time except to the extent that released information has already occurred. Unless otherwise revoked, this consent will automatically expire in 90 days.

We would gladly accept records on disc in .pdf or .tif format.
Please do NOT fax more than 50 pages. Thank you.

Signed: _____Printed Name:_____ Date: _____