Sandra Camacho-Otero, M.D.

10175 SW Barbur Blvd. Suite #213B

Portland, Oregon 97219

Phone: (503) 477-5643 Fax: (503) 200-1147

staff@portlandalternativeclinic.com

Authorization for Release of Medical Information

Patient Name:_____DOB:_____

Physician's Name (print):_____

Clinic:_____Phone number:_____

I authorize Sandra Camacho-Otero M.D. to receive my health information pertaining to:

☐ ALL MEDICAL RECORDS ☐ Information Relating to:_____
(Within the last 2 years)

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV / Aids, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Please initial by any of the following records that you would like included in your medical record.

Records that you do not initial cannot be released

_____Drug/alcohol abuse/treatment & Diagnosis _____Sexually transmitted diseases

_____HIV / AIDs diagnosis /treatment / testing _____Mental Illness or psychiatric diagnosis/treatment

FAX to: 1.503.200.1147 Care of Sandra Camacho-Otero M.D.

Mail to: 10175 SW Barbur Blvd #213B Portland, Or. 97219 care of Sandra Camacho-Otero M.D.

Email to: staff@portlandalternativeclinic.com

Patient Rights: I understand I do not have to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment). I have the right to revoke this authorization at any time, provided I do so in writing. If I revoke my Authorization the provider will no longer use or disclose information about me for the reasons covered. Release expires 180 days from date of release.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____Date:_____Phone number:_____

(Signature of Patient or Representative)

Print Name:_____IF Representative signed: Representative relationship to Patient_____