PO Box 16308
Portland, OR 97292

Phone: 503-255-2343
FAX: 503-255-2344

Medical Records Release to Self

We need your permission to release any records from our facility. By signing this from you authorize Northwest ADHD Treatment Center to release your records to you. A separate form is required to release your records to a third party.

Client Name: ____ **DOB:** __________________
Address: ____ Telephone: ______________
City, State, Zip: ____ Fax: __________________

Referring provider may follow up to discuss rationale for and implications of personally requested records.

I authorize my records to be released to myself through the following method(s):
(Please initial all that apply)

_____By mail
_____By fax
_____On data disc
_____On flash drive (Provided by patient. Must be new in package.)

Signature
I have read this authorization and understand it.

Client signature: ____ Date: _______________

Parent/Guardian/Representative signature: ___________________________ Date: _______________

If personal representative, print name:
Relationship to client: ☐Parent ☐ Legal guardian ☐ Power of Attorney/Healthcare ☐ Other: