Lori Horan Soule N.D., L.Ac.
Soule Healthcare
3526 SW Corbett Ave.
Portland, OR 97239
Phone: 503-224-9010
fax: 503-224-5551

RELEASE OF RECORDS REQUEST

I, _____, authorize the Center for Traditional Medicine, P.C.* to release copies of my:

___Laboratory Test Results

___Radiology Reports

___X-Rays

___Chart Notes

___Complete Medical Record

to: Dr. Lori Horan Soule N.D., L.Ac.
Soule Healthcare
3526 SW Corbett Ave.
Portland, OR 97239
Phone: 503-224-9010 Fax: 503-224-5551

For the purpose of: continuity of care.

Signature of Patient or Guardian:_____

Print name:_____Date of Birth:_____

Date:_____Witness:_____

Expiration date: _____(1 yr.)

*{Center for Traditional Medicine fax number is 503-636-2734}