
Doctors Name

Address

I hereby authorize and request you to release information to:

GREGORY C. RICHTERICH, MD
992 Country Club Rd, STE 201
Eugene, OR 97401
PH# (541) 485-7546 FAX# (541) 345-5254

I would like the following information released to the above stated provider:

- Complete Medical Records
- Labs or Pathology
- This authorization is limited to the following:

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

PATIENT NAME PRINTED: _____

DATE OF BIRTH: ____/____/____ TODAY'S DATE: ____/____/____

PATIENT OR GUARDIAN SIGNATURE: _____

RELATIONSHIP IF NOT PATIENT: _____