

Elysian Health
124 NW D St.
Grants Pass OR 97527



Phone: 541-214-2601
Fax: 541-507-4141

Patient Release of Medical Records

Patient Name: _____	DOB: _____
Address: _____	
Phone (s): _____	
Email: _____	

I, _____, authorize Elysian Health to access all of my available records, including but not limited to labs, images, studies, and pathology available on EPIC and through other local entities. I understand the information in my health record may include information relating to cancer diagnosis, sexually transmitted disease or HIV/AIDS. It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse.

Purpose for request: Primary Care

Type of Request: All Records

Signature of Patient or Representative

Date

Printed Name of Patient or Representative

Relationship to Patient