



Clary Document Management, Inc.
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AUTHORIZATION TO RELEASE PSYCHOLOGY RECORDS

Patient's Name: _____

Date of Birth: _____

Address: _____

Day Phone: _____

Email: _____

I request that all medical records of the patient
named above to be released from:

Robert B. Basham, PhD
1312 SW 16th Ave
Suite 102
Portland, OR 97201

Send all psychology records to:

same address as above \$20

or

other address below \$20

Name: _____

Address: _____

Email: _____

Fax :

Year of Last Visit

Reason for Release of Information: **Personal Use**

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws. **I understand I will pre-pay \$20 to reproduce the records and reports.**

Patient Signature Date _____

Patient Representative Signature Your Authority to Sign on Behalf of Patient Date _____

STATE/Commonwealth of _____
County of _____

The foregoing instrument was acknowledged before me the ____ day of _____, 20__

by _____

Notary Public