



Douwe Rienstra, MD

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RELEASE OF MEDICAL INFORMATION

I authorize Dr. _____ to furnish the following to Dr Rienstra

- _____ all medical information
- _____ history & physical examination
- _____ office records
- _____ diagnosis and problem lists
- _____ lab reports
- _____ X-rays
- _____ consultation reports
- _____ hospital discharge summaries

concerning _____
(name)

I waive on behalf of myself and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of such information.

I understand that my records may contain information protected by law. If information is initialed below, and it is part of my medical record, I specifically authorize its release.

- _____ drug/alcohol diagnosis, treatment, and referral
- _____ HIV test, test results, and information on this and other sexually transmitted diseases
- _____ mental health treatment

Signed _____
(Patient or Guardian)

Date _____

Witness: _____