



**ASHLAND ORTHOPEDIC ASSOCIATES, LLP**

Physicians and Surgeons  
269 Maple Street  
Ashland, Oregon 97520

CHART # \_\_\_\_\_

DOUGLAS P. MORRISON, M.D.  
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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Administrator  
Susan Bates

Phone (541) 482-4533  
Fax (541) 488-5102

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize ASHLAND ORTHOPEDIC ASSOCIATES to release a copy of the medical information for \_\_\_\_\_ (please print full name of patient) \_\_\_\_\_ (date of birth) to the patient or the patient's legal representative. The information will be used on my behalf for the following purpose(s):

\_\_\_\_\_

By initializing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

\_\_\_\_\_ Clinician office chart notes

\_\_\_\_\_ Billing statements

\_\_\_\_\_ Other

I understand that other medical records may exist. If more information is available for this patient it may be obtained from the following sources:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Signature of patient or person authorized by law)

\_\_\_\_\_ (Phone Number)