Request for Records
(Please do not send records by CD)

Patient's Name: _____
Date of Birth: _____

I authorize the release of my medical records from:
Previous clinic/Provider
name:_____
Address:_____
_____
___ Phone:_____ Fax:_____

Please forward to CANYON FAMILY HEALTH 1095 N 1ST ST STAYTON, OR 97383-1203 Phone: (503) 767-3226 Fax: 503-767-3227

Information to be included
****Please initial the following:**
___Chart notes and Medication List
___Mental Health diagnosis and assessment (no chart notes)
___Drug/Alcohol Treatment
___Other (Please Specify) _____

Patient Signature: _____
Date:_____