Brian Moreaux, D.O. Dan Sengenberger, D.O.
Mick Juarez, D.O.

850 Siskiyou Boulevard, Suite 7   Ashland, OR 97520-2237

Release to OCLLC

Date ____________

To ______________________________

____

____

Please release the following items from my medical record to:

___ Brian Moreaux, D.O.

___ Dan Sengenberger, D.O.

___ Mick Juarez, D.O.

Information being requested:

___ History & Physical   ___ Laboratory Results

___ X-Ray   ___ Other:

___ MRI

Printed Name ______________________________

Signature ______________________________

Date of Birth ______________________________

BRIAN MOREAUX, D.O. DAN SENGENBERGER, D.O.
MICK JUAREZ, D.O.

850 Siskiyou Boulevard, Suite 7 *Ashland, OR 97520-2237*
Phone: 541-482-0342 *Fax: 541-482-6986*

Release from OCLLC

Please release the following items from my medical record to:

____

____

____

The records I would like sent are from my visits with:

___ Brian Moreaux, D.O ___Dan Sengenberger, D.O. ___ Mick Juarez D.O.

Unless otherwise specified below, all official medical records will be sent. If you wish the information sent to be limited in any way, please indicate so here:

This authorization is limited to the following treatment:

____

This authorization is limited to the following time period:

____

This authorization is limited to a worker's compensation claim for injuries of________________ (date).
This authorization is limited to a motor vehicle accident claim for injuries of__________________ (date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Date ______________________________

Printed Name______________________________

Signature ______________________________

Date of Birth ______________________________