

BRIAN MOREAUX, D.O. **DANIEL SENGENBERGER, D.O.**

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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. ___ Daniel Sengenberger 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 _____