

Authorization to Release Medical Information



MEDICAL RECORD NUMBER: _____

Patient Name _____
Alternate Name _____
Birthdate _____
Current Address _____
Daytime Phone # _____
Email address _____

PREFERRED METHOD OF DELIVERY

- Mail
 Fax
 Pick-up
 Secure Message*
**Email address required*

REASON FOR RECORD

- Medical Care
 Benefits
 Litigation
 Workers' Comp
 Individual Request
 Other _____

I AUTHORIZE INFORMATION RELEASED FROM:

Name of Office

Name of Clinician

Address

City, State, Zip

PLEASE SEND MY RECORDS TO:

Facility to Receive Information

Clinician Name

Address

City, State, Zip

Type of Information to be Released *There may be fees for providing copies.*

SPECIFIC INFORMATION ONLY, INCLUDING:

___ Pap Results	___ Radiology Reports	___ Immunizations	___ Operative Report	Dates: _____
___ Mammogram Reports	___ History and Physical	___ OB / GYN Records	___ Pathology Report	Dates: _____
___ Medications/Therapy	___ Genetics/Amniocentesis	___ Other: _____	___ Ultrasound Report	Dates: _____
___ Lab	___ Office Visits			

GENERAL MEDICAL RECORDS (FROM THE PAST TWO YEARS ONLY)

PROTECTED OR SENSITIVE INFORMATION. Certain information cannot be released without specific authorization. Please initial below **if you agree to release the following:**

- ___ I recognize that the information disclosed may contain DRUG/ALCOHOL information that is protected by federal and state law. I specifically consent to disclosure of such information.
- ___ I recognize that the information disclosed may contain MENTAL HEALTH information that is protected by federal and state law. I specifically consent to disclosure of such information.
- ___ I recognize that the information disclosed may contain data regarding HIV/AIDS testing. I specifically consent to disclosure of such information.
- ___ I recognize that the information disclosed may contain data regarding GENETIC TESTING. I specifically consent to disclosure of such information.

PERMISSION TO FAX INFORMATION: I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. Initial: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken relying upon it) by writing to the HIPAA Privacy Officer at the Administrative office (see reverse). Once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without my knowledge or consent. However, federal or state law may restrict the re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on _____ (insert applicable date or event).

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name or Name of Patient's Legal Representative (if applicable)

Relationship to Patient

Office Locations

Administrative Office

7650 SW Beveland Street,
Suite 200
Portland, OR 97223
503.601.3615 office
503.646.1683 fax

Gateway Office

177 NE 102nd Avenue
503.734.3800 office
503.734.3808 fax

Hillsboro Office

7431 NW Evergreen Parkway,
Suite 205
Hillsboro OR 97124
503.840.3400 office
503.840.3409 fax
Opening in June 2016

Lloyd District Office

700 NE Multnomah Street,
Suite 1600
Portland, OR 97232
503.249.5454 office
503.249.5498 fax

Newberg Office

1003 Providence Drive, Suite 340
Newberg, OR 97132
503.538.2698 office
503.554.9328 fax

Oregon City Office

1508 Division Street, Suite 205
Oregon City, OR 97045
503.657.1071 office
503.657.3321 fax

Peterkort North Office

9701 SW Barnes Road, Suite 200
Portland, OR 97225
503.734.3700 office
503.473.8462 fax

Peterkort South Office

9555 SW Barnes Road, Suite 100
Portland, OR 97225
503.292.3577 office
503.292.3947 fax

Tualatin Office

19250 SW 65th Avenue, Suite 300
Tualatin, OR 97062
503.692.1242 office
503.691.3615 fax

Northwest Gynecology Center

Lloyd District Office

700 NE Multnomah Street,
Suite 1650
Portland, OR 97232
503.734.1850 office
503.734.1855 fax

Northwest Gynecology Center

Peterkort Office

9701 SW Barnes Road, Suite 150
Portland, OR 97225
503.734.3535 office
503.734.3530 fax

Northwest Gynecology Center

Tualatin Office

19250 SW 65th Avenue, Suite 325
Tualatin, OR 97062
503.692.1242 office
503.691.3615 fax

Northwest Perinatal Center

Eastside Office

5050 NE Hoyt Street, Suite 230
Portland, OR 97213
503.482.1800 office
503.482.1805 fax

Northwest Perinatal Center

Westside Office

9701 SW Barnes Road, Suite 299
Portland, OR 97225
503.297.3660 office
503.297.7637 fax