Authorization to Release Medical Information

Women's Healthcare Associates LLC

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 St, Ste 200
Portland, OR 97223
503.601.3615 office
503.646.1683 fax

Bridgeview Office
1130 NW 22nd Ave, Ste 520
Portland OR, 97210
503.274.4800 office
503.274.4917 fax

Gateway Office
10566 SE Washington St Portland, OR 97216
503.734.3800 office
503.734.3808 fax

Hillsboro Office
7431 NE Evergreen Pkwy, Ste 100
Hillsboro OR 97124
503.840.3400 office
503.840.3409 fax

Newberg Office
1003 Providence Dr, Ste 340
Newberg, OR 97132
503.538.2698 office
503.554.9328 fax

Oregon City Office
1508 Division St, Ste 205
Oregon City, OR 97045
503.657.1071 office
503.657.3321 fax

Peterkort North Office
9701 SW Barnes Rd, Ste 200
Portland, OR 97225
503.734.3700 office
503.473.8462 fax

Tabor Office
5050 NE Hoyt St, Ste 230
Portland, OR 97213
503.249.5454 office
503.249.5498 fax

Tualatin Office
19250 SW 65th Ave, Ste 300
Tualatin, OR 97062
503.692.1242 office
503.691.3615 fax

Northwest Gynecology Center Peterkort Office
9701 SW Barnes Rd, Ste 150
Portland, OR 97225
503.734.3535 office
503.734.3530 fax

Northwest Gynecology Center Tualatin Office
19250 SW 65th Ave, Ste 325
Tualatin, OR 97062
503.692.1242 office
503.691.3615 fax

Northwest Perinatal Center Eastside Office
5050 NE Hoyt St, Ste 230
Portland, OR 97213
503.482.1800 office
503.482.1805 fax

Northwest Perinatal Center Westside Office
9701 SW Barnes Rd, Ste 299
Portland, OR 97225
503.297.3660 office
503.297.7637 fax