

# 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:

<input type="checkbox"/> Pap Results	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Operative Report	Dates: _____
<input type="checkbox"/> Mammogram Reports	<input type="checkbox"/> History and Physical	<input type="checkbox"/> OB / GYN Records	<input type="checkbox"/> Pathology Report	Dates: _____
<input type="checkbox"/> Medications/Therapy	<input type="checkbox"/> Genetics/Amniocentesis	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Ultrasound Report	Dates: _____
<input type="checkbox"/> Lab	<input type="checkbox"/> 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