Authorization for Release of Medical Information

Patient's Full Name: (Print): ______________________________

Previous Name: ______________________ Date of Birth: ______________________

RELEASE FROM:

Clinic, Hospital or Physician:: ______________________________

Address: ______________________________

City, State: ______________________________

Telephone: ______________________ FAX: ______________________

RELEASE TO:

Clinic, Hospital or Physician:: ______________________________

Address: ______________________________

City, State: ______________________________

Telephone: ______________________ FAX: ______________________

Purpose of Disclosure:

_____ Continuity of Care   _____ Change of Doctor
_____ Personal   _____ Other (Specify)

HIPAA laws require that we disclose only the "minimum information necessary to achieve the purpose" of the medical information request.
Please indicate below what information is needed for continuity of care, i.e. pap smear, mammogram, well woman visit, most recent lab work, surgery operative note:

____

____

I further understand that my medical record may include one or more of the following and by my signature below, I understand and agree that this information will be disclosed.

HIV/AIDS Information   Genetic testing information
Mental Health Information   Drug/Alcohol diagnosis, treatment or referral information

Unless revoked earlier, this consent will expire 180 days from date of signing. To revoke this request, please contact Bend Gynecology at 541.389.0450.

Patient Signature: ______________________ Date: ____________ Phone: ____________
(Or Patient Representative)

Please Note: There is a $25 charge for a personal copy of your records.
The Oregon Medical Association allows us 30 days to copy and release records.