Bend Gynecology
Women's Healthcare & Surgery

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, Zip: ____

Telephone: ____________________________ Fax:____________________________

RELEASE TO:

Clinic, Hospital, or Physician: ______________________________________

Address: ____

City, State, Zip: ____

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 the date of signing. To revoke this request, please contact Bend Gynecology at (541) 389-0450.

Patient Signature: ______________________________ Date: ____________________
(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.

1102 NE 4th St. Bend, OR 97701 Phone: (541) 389-0450
Fax: (541) 389-9567