PORTLAND OBSTETRICS & GYNECOLOGY ASSOCIATES, P.C.

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1130 NW 22nd Ave, Suite 120
Portland, OR 97210
Telephone: 503-229-7353
Fax: 503-229-7255

9555 SW Barnes Rd., Suite 260
Portland, OR 97225
Telephone: 503- 624-2044

Authorization to OBTAIN Medical Information for Portland Obstetrics & Gynecology Associates, P.C.

Patient Name: _____
(First) *(Middle)* *(Last)*
Date of Birth: _____ Social Security No: _____
Current Address: _____
Daytime Phone Number: _____

Purpose of Request
- ☐ Personal
- ☐ Medical care
- ☐ Benefits
- ☐ Litigation
- ☐ Workman's Comp
- ☐ Other _____

I authorize information release from:

Name: _____
Address: _____
_____
Telephone: _____ Fax: _____

Please send to:

Portland Obstetrics & Gynecology Associates, PC
1130 NW 22nd Avenue, Suite 120
Portland, Oregon 97210
Telephone: 503-229-7353 **Fax: 503-229-7255**

Type of Information to be Released

☐ **Specific Information Only Please**

____ Pap Results
____ Mammogram Reports
____ Medications/Therapy
____ Lab Reports
____ History & Physical
____ Genetics/ Amniocentesis
____ Immunizations
____ Ob/Gyn Records
____ Radiology Reports
____ Other _____
____ Operative Reports Dates _____
____ Pathology Reports Dates _____
____ Ultrasound Reports Dates _____

☐ **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:**

_____ *Initials* I recognized 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.

_____ *Initials* I recognized 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.

_____ *Initials* I recognized that the information disclosed may contain HIV/AIDS information that is protected by federal and state law. I specifically consent to disclosure of such information.

_____ *Initials* I recognized that the information disclosed may contain GENETIC TESTING information that is protected by federal and state law. I specifically consent to disclosure of such information.

Permission to Fax Information: ☐ Yes ☐ No

_____ *Initials* I specifically consent to the faxing of my records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed.

- By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.
- You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.
- You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

_____ _____
Signature of Patient or Patient's Legal Representative *Date*

_____ _____
Print Patient's name or Patient's Legal Representative (if applicable) *Date*