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Authorization to RELEASE Medical Information from 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 to be sent to:

Name: _____
 Address: _____

 Telephone: _____ Fax: _____

* Records sent to outside physicians/clinics are provided as a courtesy.
 ** Fees may apply: the rate is \$25 for the first 10 pages and .25 cents each additional page plus postage

Type of Information to be Released

Specific Information Only Please

- | | | |
|--|--|---|
| <input type="checkbox"/> Pap Results | <input type="checkbox"/> Genetics/ Amniocentesis | <input type="checkbox"/> Operative Reports Dates _____ |
| <input type="checkbox"/> Mammogram Reports | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Pathology Reports Dates _____ |
| <input type="checkbox"/> Medications/Therapy | <input type="checkbox"/> Ob/Gyn Records | <input type="checkbox"/> Ultrasound Reports Dates _____ |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports | |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Other _____ | |

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

Patient's or Legal Representative's Personal Identification Verified