# AUTHORIZATION TO RELEASE MEDICAL RECORDS

DrN GYN
17020 Pilkington Rd, Lake Oswego OR 97035
Ph: 503-908-1646 Fax: 503-908-1648

I authorize the use and/or disclosure of my protected health information (medical records) described below:

PATIENT NAME:_____ DOB:_____

I authorize the following to RELEASE my protected health information (Please include name of facility/provider, address, phone number and FAX number):

_____

I authorize the following to RECEIVE my protected health information (Please include name of facility/provider, address, phone number and FAX number):

_____

The purpose of the release is: _____ At the request of the individual _____ Diagnostic Evaluation
_____ Coordination of Care _____Change of physician _____Other:_____

Please release the following:
_____ Labs _____ Imaging _____ Pathology _____ Operative Reports _____ Chart Notes
_____ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.
_____ HIV/Aids information _____ Genetic testing information _____Mental Health _____Drugs/Alcohol diagnosis, treatment, or referrals

Please send my records for the following dates: From _____ through _____

- ✓ This authorization will expire 180 days from the date signed.
- ✓ You have the right to revoke this authorization at any time provided you do so in writing. If you revoke your authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, butwe cannot take back any disclosures already made with your permission. To revoke your records release from DrN GYN with this authorization, please send a written statement to our clinic at 17020 Pilkington Rd, Lake Oswego OR 97035, that identifies the date you signed the authorization, the recipient of the information in the authorization and state you are revoking this authorization.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____
_____
(signature of the recipient or representative) Relationship if signed by a representative

_____ **If over 50 pages, please mail to clinic at above address
(Date)