2951 Doctors Park Drive
Medford, OR 97504
roguewomenshealth.com
Phone: 541-200-2646

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

I authorize my records to be released from:

_____
Name of Clinic/Physician

_____
Mailing Address

_____
City State Zip Code

Phone (____) _____Fax (____) _____

Please send my records to:

_____
Name of Clinic/Physician

_____
Mailing Address

_____
City State Zip Code

Phone (____) _____Fax (____) _____

Purpose of the release: Changing OB/Gyn ___ Insurance ___ Legal ___ Referral/Consult ___ Other ____

Please check type of information to be released:

____All Medical Records ____Chart/Office Notes ____Surgical/Operative Reports

____Hospital Records ____Lab and Pathology Reports ____ X-Ray/CT/Ultrasound Reports ____ 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 ____Mental Health Information ____Genetic Testing

____Alcohol/chemical dependency information ____ Sexually transmitted disease information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal law restricts re-disclosure of alcohol/chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to re-disclosure. This authorization is valid for 6 months and may be revoked in writing at any time prior to six months.

_____ _____
Signature/Authorization to Release Information Date