

Bend Obstetrics & Gynecology, LLC

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
Release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please Note: We are a specialty practice and laws require that we request and/or release only the minimum necessary information about you. Therefore, please write below what is needed for your visit i.e.: pap smear, mammogram, well woman visit or previous birth records, etc.

Health care information relating to the following treatment, condition, or dates:

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. I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

By **initialing** the spaces below I specifically authorize the release of the following information:

_____ HIV/AIDS information

_____ Mental health information

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment or referral information

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME. UNLESS REVOKED EARLIER, THIS CONSENT WILL EXPIRE 180 DAYS FROM THE DATE SIGNED. THE OREGON MEDICAL ASSOCIATION GUIDELINES ALLOWS US 30 DAYS TO COPY AND RELEASE RECORDS.