



Patient		
Preferred Name/Maiden Name/Other		
Date of Birth (MM/DD/YYYY)	Phone number	
Street Address or PO Box		
City	State	Zip Code

**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

I authorize the use and disclosure of a copy of the specific health and medical information as described below:

<b>To:</b> The Fertility Center of Oregon Individual or Facility 590 Country Club Parkway, Ste A, Eugene OR, 97401 Mailing Address, City/State, Zip  <b>From:</b> _____ Individual or Facility _____ Mailing Address, City/State, Zip	541-683-1559 Phone Number  541-683-1709 Fax Number  _____ Phone Number  _____ Fax Number	The purpose of this request is: <input type="checkbox"/> Referred Medical Care <input type="checkbox"/> Transferring Primary Care <input type="checkbox"/> Relocation <input type="checkbox"/> Personal Preference <input type="checkbox"/> Clinical Research <input type="checkbox"/> Billing Purposes <input type="checkbox"/> Personal Request <input type="checkbox"/> Legal Matter <input type="checkbox"/> Other: _____ The purpose of this request is at the request of the individual
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**Please INITIAL all types of information to be released:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> *All Medical Records (Last 2 years) | <input type="checkbox"/> Physician Notes      | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> Hospital Records/Consultations      | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Billing Information   |
| <input type="checkbox"/> Imaging Reports                     | <input type="checkbox"/> Other: _____         |  |

\*All Medical Records includes Physician Notes, Lab/Pathology reports, Hospital Records/Consultations and Immunization Records for the last 2 years unless otherwise specified

If the information to be used/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 used or disclosed if I **place my initials** in the applicable space next to each type of information:

<input type="checkbox"/> Drug/Alcohol diagnosis, treatment or referral information	<input type="checkbox"/> HIV/AIDS information
<input type="checkbox"/> Mental Health information – including provider notes	<input type="checkbox"/> Genetic testing Information

**Copy Format:**      Electronic      Paper      Fax

***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. I specifically give authorization to fax or electronically provide my medical information. I understand that risk is involved in electronically transmitting records and confidentiality at the receiving end cannot always be guaranteed. All disclosed information will contain a confidentiality statement and instructions for returning misdirected information. \_\_\_\_\_(INITIALS)***

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

- (1) Creating health information about you to be disclosed to a third party; or
- (2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that, 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*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to: Women's Care HIPAA Compliance Officer, P.O. Box 70368 Springfield Oregon 97475 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. Records will be released within 30 days of receipt of this authorization.

This Authorization will expire on the earlier of \_\_\_\_\_ (date), 365 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

_____	Date: _____
Signature of Individual or Personal Representative	
_____	_____
Description of Representative's Authority	(For internal use - Center for Genetics Patient)