Center for Genetics &
Maternal-Fetal Medicine

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:

To: _____ _____
Individual or Facility — Phone Number

_____ _____
Mailing Address, City/State, Zip — Fax Number

From: Center for Genetics & Maternal-Fetal Medicine **541-349-7600**
Individual or Facility — Phone Number

P.O. Box 70368, Springfield OR 97475 541-686-8330
Mailing Address, City/State, Zip — Fax Number

The purpose of this request is:
__ Referred Medical Care
__ Transferring Primary Care
__ Relocation
__ Personal Preference
__ Clinical Research
__ Billing Purposes
__ Personal Request
__ Legal Matter

The purpose of this request is at the request of the individual

Please INITIAL all types of Information to be released:

__ *All Medical Records (Last 2 years) __ Physician Notes __ Lab/Pathology Reports
__ Hospital Records/Consultations __ Immunization Records __ Billing Information
__ Imaging Reports __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:

____ Drug/Alcohol diagnosis, treatment or referral information ____ HIV/AIDS information
____ Mental Health information – including provider notes ____ 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)