AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

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

I authorize Women's Care to use and/or disclose the protected health information about me described below.

To: _____
Individual or Facility

_____
Phone Number

_____
Mailing Address, City/State, Zip

_____
Fax Number

From: Women's Care- Please circle the clinic location **Phone Number**: 541-349-7600 **Fax number:** 541-686-8330

The Fertility Center of Oregon
590 Country Club Parkway, Suite A
Eugene, OR 97401

Country Club
590 Country Club Parkway, Suite B
Eugene, OR 97401

Ten Coburg
10 Coburg Rd, Suite100
Eugene, OR 97401

Riverbend
3100 Martin Luther King Jr. Parkway
Springfield, OR 97477

Chase Gardens
360 S Garden Way, Suite 290
Eugene, OR 97401

Center for Genetics and Maternal-Fetal Medicine
3355 Riverbend Drive, Suite 210
Springfield, OR 97477

Perinatal Associates of Central Oregon
2400 NE Neff Rd, Suite B
Bend, OR 97701

The purpose of this request is:
___Transfer of Care
___Clinical Research
___Billing Purposes
___Personal Request
___Legal Matter
___Work Leave or Accommodation Request
___Other: _____

Please **INITIAL** all types of information to be released:
___ *All Medical Records (Last 2 years)
___Chart/Progress Notes
___Hospital Records/Consultations
___Billing Information
___Other: _____
__Lab/Pathology Reports
__Imaging Reports
__ Immunization Records

*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
____Mental Health information – including provider notes
____HIV/AIDS information
___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)