MT HOOD WOMEN'S HEALTH PC
24850 SE Stark St. Suite 200, Gresham OR 97030
(503) 491-9444, fax (503) 661-3430

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

1. PATIENT NAME:_____ **Birth Date**:_____

(Any previous name record may be under_____) Phone No. _____

2. I authorize Mt. Hood Womens Health, P.C. to:

☐ **Release a copy of my health information to:** ☐ **Receive my health information from**:

To/From Name:_____

Address:_____City_____State_____Zip_____

Phone: _____ Fax: _____

3. INFORMATION TO BE RELEASED: *(check any that apply)*

____ Current records (2 yr)

____ Laboratory/pathology records ____ Hospital records ____ Complete medical record
____ Ultrasound/Imaging report ____ Operative report ____ History & Physical
____ Chart Summary ____ Other _____
(Describe specific information requested)

4. FOR THE PURPOSE OF: *(check any that apply)*

____ Transfer of care ____ Continuation of care ____ Legal/Attorney ____ Insurance ____ Employer ____ Self use
____ Other:_____

5. SPECIAL RESTRICTIONS - INITIALS REQUIRED for release: If the information to be disclosed contains any of the types of records 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
_____ Genetic Testing information
_____ Mental Health information
_____ Drug/alcohol diagnosis, treatment, or referral information

6. 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: Operations Manager at 24850 SE Stark St., Suite 200, Gresham, OR 97030 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. This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

7. 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.

_____ _____ _____
Date Signature of Patient or personal representative Description of personal representative's authority: