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

2. I authorize Mt. Hood Womens Health, P.C. to: Release a copy of my health information to: Receive my heal To/From Name: Address: City State Phone: Fax: 3. INFORMATION TO BE RELEASED: (check any that apply) Laboratory/pathology records Ultrasound/Imaging report Operative report Hist Chart Summary Other (Describe specific inform 4. FOR THE PURPOSE OF: (check any that apply) Care Legal/Attorney Insurance Employer Other: 5. SPECIAL RESTRICTIONS - INITIALS REQUIRED for release: If the information to be disch of records listed below, additional laws relating to the use and disclosure of the inform and agree that this information will be disclosed if I place my INITIALS in the applical information. HIV/AIDS information Mental Health information Genetic Testing information Mental Health information Drug/alcohol diagnosis, tree will no longer use or disclose information about you to be the purpose of research. You have the right to revoke this Authorization at any time, provided evoke your Authorization, we will no longer use or disclose information about you to be the purpose of research. You have the right to revoke this Authorization at any time, provided evoke your Authorization, we will no longer use or disclose information about you for the reask Authorization, but we cannot take back any uses or disclose information about you for the reask Authorization, but we cannot take back any uses or disclose information identified in this Authorization at the volume of the information identified in this Authorization, the recipient of the information identified in this Authorization in the Nathorization	City State Zip Fax: Current records (2 yr) hology records Hospital records Complete medical record aging report Operative report History & Physical (Describe specific information requested) GE OF: (check any that apply) Transfer of care Continuation of Attorney Insurance Employer Self use NS - INITIALS REQUIRED for release: If the information to be disclosed contains any of the types only additional laws relating to the use and disclosure of the information may apply. I understand information will be disclosed if I place my INITIALS in the applicable space next to the type of Insurance Information Drug/alcohol diagnosis, treatment, or referral information may information Inguinformation Inguire of Continuation of the purpose of: (1) Creating health information about you to be disclosed to a third party; or (2) Foot have the right to revoke this Authorization about you to be disclosed to a third party; or (2) Foot have the right to revoke this Authorization about you for the reasons covered by your written were will no longer use or disclosures already made with your permission. To revoke this Authorization about you for the reasons covered by your written ment to: Operations Manager at 24850 SE Stark St., Suite 200, Gresham, OR 97030 that identifies ization, the recipient of the information identified in this Authorization, and state that you are revoking theories are the suppose of the recipient of the information identified in this Authorization, and state that you are revoking the recipient of the information identified in this Authorization, and state that you are revoking that dealed of signing days from the date of signing (date), 180 days from the date of signing date that you are revoked that you are already made and you have the college of the propose	1. PATIENT NAME:	Birth Date:			
Release a copy of my health information to: Receive my heal To/From Name: Address: City State Phone: Fax: Laboratory/pathology records Ultrasound/Imaging report Chart Summary Other Chart Summary Other Legal/Attorney Insurance Describe specific information to be disclored site of records listed below, additional laws relating to the use and disclosure of the information. HIV/AIDS information Mental Health information Genetic Testing information Drug/alcohol diagnosis, tre Describes a copy of my health information about you for the rease relating to the use and disclosure of the information mental health care or treatment is for the purpose of: (1) Creating health information about you to be the purpose of research. You have the right to revoke this Authorization at any time, provided evoke your Authorization, we will no longer use or disclosure already made with you premisulesse send a written statement to: Operations Manager at 24850 SE Stark St., Suite 200, Gre late you signed this Authorization, the recipient of the information identified in this Authorization. This Authorization in well explored the content of the information identified in this Authorization. This Authorization in well explored the content of the information identified in this Authorization. This Authorization in the explored the content of the information identified in this Authorization. This Authorization on the earlier of (date), 1 (date	City State Zip Fax: Complete medical records Complete medical record aging report Operative report History & Physical (Describe specific information requested) Complete medical record History & Physical (Describe specific information requested)	(Any previous name record may be ur	nder	er) Phone No		
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