Authorization to Disclose Health Information

This authorization must be written, dated and signed by the patient or by a person authorized by law.

_____ _____ _____
Patient Name | Previous Name | Date of Birth

_____ _____
Address | Social Security Number

_____ _____
City, State, ZIP | Daytime Telephone Number

I authorize records be released for the purpose of: _____

RELEASE RECORDS TO / FROM: *(Please Circle)*

_____
Doctor/Office Name

_____
Address

_____
City, State, ZIP

_____ _____
Phone Number | Fax Number

RELEASE RECORDS TO / FROM:

Bridgeview Women's Health, LLC.

1130 NW 22nd Avenue, Suite 520

Portland, Oregon 97210

P: 503-274-4800 F: 503-274-4917

By **INITIALING** spaces below, I specifically authorize the release of the following medical records, if records exist:

_____ Most recent two year history _____ Office visit notes _____ Transcribed hospital notes
_____ Laboratory reports _____ Pathology reports _____ Diagnostic imaging reports
_____ Billing statements _____ Other: _____

The following items will not be included in the release of your medical record. Each item must be initialed to be included with the other documents:

_____ HIV/AIDS related records _____ Genetic testing information _____ Mental health information
_____ Drug/alcohol diagnosis, treatment or referral information. (Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form.)

_____ This authorization is limited to the following treatment _____
_____ This authorization is limited to worker's compensation claim for injuries on date of _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from date of signing or for the period reasonably needed to complete the request. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

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 protected under Federal Law.

_____ _____
(SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW) *Electronic signatures are not accepted.* (DATE)

Circle one: I DO / DO NOT authorize records to be FAXED. *APPOINTMENT DATE:_____