AUTHORIZATION

TO USE/DISCLOSE HEALTH INFORMATION

Name of Patient: **Date of Birth:** **Women's Health Today, Physician's Name:**

I authorize, **WOMEN'S HEALTH TODAY, 5050 NE HOYT, Suite # 362, Portland, Oregon 97213 Phone 503-239-6800 Fax 503-239-0006**

____ To obtain my prior health records from the following physician; (for my upcoming visit at Women's Health Today)

____ To send my health records to the following physician; (for my upcoming visit with said provider)

____ Other ____ (there may be fees for providing copies)

Physician Name: ____ Clinic/Hospital Name: ______________________________
Address: ____ City, State & Zip: __________________________________
Phone: ____ Fax: ____

Consisting of:

____ PAP Results (date) ______________________________
____ Ultrasound and/or Mammogram reports (date) ________
____ OB records (date) _________________________________
____ Operative Findings (type of surgery) ________________
____ History and Physical (date) _______________________
____ Laboratory reports (type) ___________________
____ Pathology report __________________________
____ General Medical Records (Past 2 years only)
____ Other ____________________________________
____ Outside Medical Records ___________________

For the purpose of: ____Insurance change ____Continuing care ____Transferring care ____ Specialist referral ____ Other____________

If the information to be 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 disclosed if **I place my initials** in the applicable space next to the type of information:

_________ (Initials) Genetic testing information
_________ (Initials) Mental health information
_________ (Initials) HIV/AIDS or Sexually transmitted disease information
_________ (Initials) Drug/alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed by this authorization may be subject to re-disclosure and is no longer protected under federal law. However, I also understand that federal or state laws may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information, drug/alcohol diagnosis and/or treatment of referral information.

You do not need to sign this authorization; refusal to sign the Authorization will not aversively affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the Authorization is necessary to make that disclosure.

You have the right to revoke this Authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Women's Health Today; attn: Medical Records at the address above and state that you are revoking this authorization.

I have reviewed and understand this Authorization. Unless revoked earlier, this authorization will expire 180 days from date of signing or on (insert applicable date or event) ____________________.

By ____ Date: _____________
(Patient or Patient's Representative)

Description of Representative's Authority: ____

Provider/Office approval

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PLEASE ALLOW OUR OFFICE (15) TO (30) DAYS TO COPY AND RELEASE RECORDS