Northwest Fertility Center

• Phone (503) 227-7799 • Fax (503) 227-5452

Patient Authorization for Release of Health Records

1. I authorize (Dr.)_____to disclose information from the health records of: _____
   (patient)
   MRN#:_____ Date of Birth:_____

2. The information is to be **disclosed to**: Dr._____
   Address: _____
   City, State,Zip: _____
   Phone/Fax: _____

   I authorize this information to be disclosed in the following ways:
   □ Written/Photocopy/Paper □ Verbal □ Fax

   Purpose of disclosure:_____
   Dates of Treatment: _____

   Specific reports to be disclosed:
   - □ Entire Health Record (including, but not limited to: information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   - □ Progress Notes □ Laboratory Reports □ Operative Reports
   - □ Discharge Summary □ Radiology Reports □ Consultations
   - □X-ray films or other image □ Photographs/Videotapes □ Other MD records
   - □ Other (Specify)_____

   I give specific authorization to disclose the following information:
   □ HIV test results □ Documentation of AIDS diagnosis
   □ Drug and alcohol □ Psychiatric/Mental Health

   I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke authorization by notifying The Northwest Fertility Center in writing.

   My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by HIPAA privacy regulations.

   Unless revoked earlier, this authorization expires in one year unless I specify another time.

   The release of the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

   _____ _____
   Signature of Patient Date

   _____
   Printed Name of Patient