Consent to Disclose / Obtain Information

Patient Name ____ *Former Name(s)* ______________________________

Phone ________________ *Cell*__________________ *SS#* _____________________ *Date of Birth* _________________

Purpose of Release Request: ❒ Change Doctors ❒ Doctor Consultation ❒ Moving/relocating

❒ Legal reasons ❒Self ❒Other:____

Type of Information to Be Released—General Medical Information. Please initial.

______ .All records for last ____ year(s) ______ .Medication record ______ .Lab test results

______ .Imaging reports ______ .Operative reports ______ .Other ____

Note: I understand that the medical information released by this authorization may include information concerning treatments of physical or mental illness, past medical history, alcohol/Drug abuse, HIV/AIDS or other sensitive information.

I authorize information to be released **From**: Please be *complete* and *specific:*

Name of Facility ____Phone# _______________fax#:_______________

Street Address____________________________________City_______________State___________Zip_____________

I authorize information to be released **To**: Please be *complete* and *specific*

Name of Facility ____Phone#:_____________ fax#:_______________

Street Address ___________________________________City_________________State________Zip_______________

Permission to fax/electronically transfer information to: ____.

I have read this authorization and I understand it. Unless revoked, this authorization expires: ❒ in 90 days, or______________________________. Applicable date or event.

Signature of patient or personal representative: ____date___________________

Describe personal representative's authority: ____date____________________

PATIENT INFORMATION: You may 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: Salem Women's Clinic, Attn: Medical Records 1395 Liberty St SE, Salem, OR 97302 and state that you are revoking this authorization.