VIVA! GYN

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Phone (541) 323-3747 FAX: (541) 323-3760

☐ No fee for patient's requesting records of 10 pages or less
☐ $25.00 Fee for patient's requesting to have copies of records of more than 10 pages
☐ No fee for records sent to another medical office or medical facility

AUTHORIZATION TO USE AND DISCLOSE HEALTH CARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize the release of health care information of the patient named above:

RECORDS FROM:	**RECORDS TO:**
Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
______________________	______________________
City: ______________________	City: ______________________
ST, ZIP: ______________________	ST, ZIP: ______________________
Telephone: ______________________	Telephone: ______________________
FAX: ______________________	FAX: ______________________

Please Note: We are a specialty practice and laws require that we request and/or release only the minimum necessary information about you. Therefore, please write below what is needed for your visit i.e.: pap smear, mammogram, well woman visit or previous birth records, etc.

☐ Health care information relating to the following treatment, condition, or dates:

____

____

☐ 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. I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

By **initialing** the spaces below I specifically authorize the release of the following information:

__________ HIV/AIDS information

__________ Mental health information

__________ Genetic testing information

__________ Drug/alcohol diagnosis, treatment or referral information

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME. UNLESS REVOKED EARLIER, THIS CONSENT WILL EXPIRE 180 DAYS FROM THE DATE SIGNED.
THE OREGON MEDICAL ASSOCIATION GUIDELINES ALLOWS US 30 DAYS TO COPY AND RELEASE RECORDS.