Oregon Fertility Institute
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RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Other Names Used: _____

I hereby authorize _____
(***PAST*** *clinic, hospital, or doctor)*

_____
(*address, phone number, or fax number of doctor -* ***REQUIRED***)

to release copies of my medical records and other information concerning my diagnosis and treatment.

Purpose of Release

- ☐ Referral/Consultation
- ☐ Changing Doctors
- ☐ Moving/Relocation
- ☐ Legal Reasons
- ☐ Self Use
- ☐ Other:_____

Information to be Released

- ☐ History & Physical Exam
- ☐ Progress Notes
- ☐ Orders & Medications
- ☐ Lab & Imaging
- ☐ Operative Reports
- ☐ Mental Health Information
- ☐ Drug/Alcohol Conditions
- ☐ HIV/AIDS Information
- ☐ Genetic Information
- ☐ Other:_____

Expiration of Release

This authorization is valid for 90 days from the date of authorization, or until ____/____/____. I understand that I can revoke this authorization earlier in writing. I understand that revocation would not apply to information already released.

Disclosure & Release

I understand that I do not have to sign this authorization, and that my refusal will not affect my ability to receive care or treatment. I understand that certain circumstances may not legally require my authorization. I understand that once information is disclosed, it may be re-disclosed by the recipient without the knowledge or consent of Oregon Fertility Institute or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

_____

Patient Signature (or other person legally authorized to give consent) Date