Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

Patient Authorization to: Discuss Health Information (Verbal) with Friends and Family and/or Leave Care-Related Messages on a Messaging System for MWC purposes

INSTRUCTIONS for COMPLETING THE AUTHORIZATION

For this authorization to be valid all sections must be complete, signed, and dated by me or on my behalf by a personal representative. Treatment and/or reimbursement for services may not be withheld or conditioned on obtaining this authorization. I may refuse to sign this authorization. I understand that I have the right to a copy of this authorization form.

DISCLOSURE: This authorization is limited to VERBAL discussions/messages. No paper copies or electronic access to my health information will be provided to the persons above without specific authorization on an Asante Patient Authorization to Disclose Health Information or other equivalent authorization.

SIGNATURE: The patient's signature is required. If the patient is incapable of signing the authorization, a personal representative such as the parent or legal guardian of a minor, or someone designated in a health care power of attorney or advance directive of the patient may sign on the patient's behalf. Legal documentation showing the authority to act for the patient may be required. Examples of acceptable documentation include: Health Care Power of Attorney, Death Certificate or Court Order.

OTHER IMPORTANT INFORMATION

CANCELLATION/ REVOCATION: I may revoke (cancel) this authorization in writing at any time. The written request does not apply to information that has already been released in accordance with this authorization. To cancel this authorization, it must be in writing and signed by me or on my behalf by a personal representative. I must send a copy of this authorization and my written statement revoking this authorization to:

Medford Women's Clinic
3170 State Street
Medford, OR 97504

Notice of Privacy Practices:

I understand MWC protects all health care information. These protections and my patient rights regarding my health care information are outlined in the MWC Notice of Privacy Practices available upon request at Medford Women's Clinic.

MINORS: In the state of Oregon, minors may be able to request certain levels of confidentiality or consent to various health care matters depending on their age without parental consent. When a minor consents for treatment, as described above, Asante may require the minor to authorize disclosure of their health information. (Reference; ORS 109.675, 109.610, 109.640)

OTHERS INVOLVED IN HEALTH CARE – Medford Women's Clinic Use Only

I authorize MWC to verbally discuss information regarding medical treatment or condition, which may include protected health care information as defined below for:

[ ] **Myself** Print Name: _____ Date of Birth: _____
[ ] **My Dependent** Print Name: _____ Date of Birth: _____

[ ] I understand that MWC may practice their professional judgment in situations to discuss information with others involved in my care that may not be listed on this form.
[ ] I understand that this form **does not permit the release of my medical records.** All requests for medical records must be processed through the MWC Medical Records Department with a written request or valid authorization.

Consent to Leave Detailed Voice Message
If unable to reach me: [ ] You may leave a detailed message regarding my care with those listed on this form or with the phone number I have provided during registration. [ ] Leave a message asking me to return your call.

By checking these boxes, I authorize this specific information to be verbally shared with the individuals I've chosen to participate in my care:

[ ] Appointment Information (Includes date of appointment, time and length, provider being seen, and appointment preparation)
[ ] Insurance/Reimbursement Information/Account Billing Information (Please Note- billing information may be shared with the guarantor on the account)
[ ] All information pertaining to my treatment (e.g., diagnosis, lab results and medications)

Name of Person (first and last)	**Phone Number**	**Relationship to Patient**

I understand the instructions and information on page 1 and 2 of this authorization. Unless canceled (revoked), this authorization will expire 365 days from date of signature. This form will expire when patients reach 18 years of age.

Signature of Patient or Patient Representative_____ Date: _____
Print Name of Signature:_____Date: _____