



Southern Oregon Gynecology

Patient: _____

DOB: _____ Phone #: _____

I authorize the use and disclosure of the specific health information below

To: **From:** **To:** **From:** (Physician, Clinic, or Person):

Name Southern Oregon Gynecology
Address 2850 State St
Medford, OR 97504

Name _____
Address _____

Phone # (541) 500-4747
Fax # (866) 267-6644

Phone # _____
Fax # _____

Information to be released:

- ___ History
- ___ Operative notes/ report / type of operation:
- ___ Imaging / X-rays: Type _____
- ___ Lab, Pathology reports
- ___ Other tests and studies (list type of test / study and date performed):

- ___ Other records (please specify): _____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical records*:

(Please initial if release is authorized)

- ___ Drug and alcohol abuse
- ___ Information related to diagnosis / treatment of HIV

* Please note that a separate release is required for Behavioral Health Information

Purpose of Disclosure: Continuity of care Transfer of Care Other: _____

This authorization is valid for six months after the date of signature. The authorization may be revoked at any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

Signature of Patient or Legally Authorized Representative _____
Date