GATEWAY WOMEN'S CLINIC

177 NE 102ND AVE, PORTLAND, OR 97220

503-254-1399 FAX: 503-256-1340

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City:** _____ **State:** _____

Zip: _____ **Phone:** _____ **Previous Name (if any):** _____

PLEASE RELEASE INFORMATION FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

PLEASE RELEASE INFORMATION TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

INFORMATION TO BE RELEASED:

My health information relating to the following condition or treatment: _____

The following date range: _____ **All records:** _____

PURPOSE OF DISCLOSURE:

Patient request: _____ **Continuing Care:** _____ **Other:** _____

SENSITIVE RECORDS TO BE RELEASED: (MUST BE INITIALED BY PATIENT)

Drug/Alcohol abuse, diagnosis or treatment: _____ **HIV/AIDS testing, diagnosis or treatment:** _____

Genetic testing information: _____ **Sexually transmitted diseases:** _____ **Mental Health information:** _____

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form in order to take part in a research study OR to receive health care when the purpose it to create health information for a third party. I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that I may revoke this authorization in writing at any time by submitting my request to the Records Clerk at 177 NE 102nd Ave, Portland, OR, 97220, only if the records originated at Gateway Women's clinic. My revocation will be effective upon receipt, but will not be effective to the extent that this clinic has taken action in reliance upon this authorization. This authorization will expire 180 days from the date below unless I request a different date in writing.

Signature: _____ **Date:** _____

If signed by someone other than patient, indicate relationship: _____