

**Columbia River Women's Clinic, LLC**

1810 East 19th Street Suite 209

The Dalles, OR 97058

Phone: 541-296-5657

Fax: 541-298-5199

Dr.'s. **Mack, Faherty, Pentopoulos and Jennifer Wilde, FNP**

I, (patient name) \_\_\_\_\_ (Date of birth) \_\_\_\_\_ authorize Columbia River Women's Clinic, LLC to receive (use) or send (disclose) a copy of my health information as identified below to:

(Name and address of provider/recipient) \_\_\_\_\_

**For the following purposes:** \_\_\_ At my request for personal use \_\_\_ Sharing with other health care providers as needed \_\_\_ Other (please describe) \_\_\_\_\_

By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and/or medical records, if such information and/or records exist:

\_\_\_ Please send the entire medical record (all information) to the above-named recipient.

\_\_\_ Clinician office chart notes

\_\_\_ Laboratory reports

\_\_\_ Transcribed Reports

\_\_\_ Pathology reports

\_\_\_ Medical records needed for continuity of care

\_\_\_ Diagnostic Imaging reports

\_\_\_ Most recent five-year history

\_\_\_ Billing Statement

\_\_\_ Other: \_\_\_\_\_

I understand that, for certain information to be disclosed, state or federal laws and regulations require my specific written authorization as follows (please **initial** to verify authorized use or disclosure):

\_\_\_ \*HIV/AIDS related health information and/or records

\_\_\_ \*Genetic testing information and/or records

\_\_\_ \*Mental health information and/or records

\_\_\_ \*Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

Describe: \_\_\_\_\_

- ✓ I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.
- ✓ I also understand that the person I am authorizing to use or disclose the information may receive compensation for doing so.
- ✓ I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.
- ✓ Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or until {date} \_\_\_\_\_.
- ✓ Copy to patient when authorization is initiated by Columbia River Women's Clinic, LLC \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print patient's name

\_\_\_\_\_  
Print name of legal representative (if applicable)

\_\_\_\_\_  
Relationship to patient

