Authorization to Release Medical Information

Patient Name: _____

Date of Birth: _____

Please fill in where you would like to get records from:

_____
(Name of Doctor/ Clinic)

_____
(Address)

_____
(City, State, Zip)

The purpose of the release is diagnostic evaluation and treatment.

_____ Please send all records.

_____ Please send only _____

Please provide medical information to:

Randi R. Ledbetter, MD, P.C.
The Menopause Center
9155 S.W. Barnes Rd., Suite #219
Portland, OR 97225
(503) 297-4774 - voice (503) 297-1889 - fax

I give my permission to fax and/or send electronically. I authorize disclosure of my medical records for the purpose stated above. I further understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. I specifically authorize the release of the following confidential information: HIV test and test results and related information including high risk behavior documentation, drug/alcohol diagnosis, treatment or referral information, mental health treatment information, and genetic information. I have signed my consent (in Dr. Ledbetter's office) authorizing release of information per HIPAA regulations.

_____ _____

Patient Signature Date Parent, Legal Guardian Date