

Medical Records Release Form

I was a patient of **Randi Ledbetter MD, who retired in 2012**

My records are stored at **Northwest Women's Clinic:**

11750 SW Barnes Rd, suite 300
Portland, OR 97225 Ph 503 416-9922 Fax 503 416-9971
www.nwwc.com

I authorize Northwest Women's Clinic to release my medical records to:

1. **Me.** Please send my medical records to me by:

() Fax: _____ (Phone:) _____

() Mail: Address _____

I understand that there is a \$30 charge to mail my records to me, up to 50 pages. I will call to make payment arrangements.

OR (only one)

2. **My physician:** Dr. _____

Address _____

Ph _____ fax _____

The following records are requested: _____ All records

Or, only: _____ medical notes _____ operative reports

I understand these released records may contain STD/HIV and / mental health information and I agree to this transfer.

I understand it may take 1-2 weeks to send this information,

NAME: _____

Signature : _____

Date: _____