808 SW 15th AVENUE
PORTLAND, OR 97205
P: 503. 274 .4994

Oregon Reproductive Medicine

9555 SW BARNES RD| STE 255
PORTLAND, OR 97225
F: 503. 208.2741

Authorization to Release Medical Records To ORM

**** Please fax records to 503.208.2741 or secure email to medicalrecords@portlandivf.net****

Patient Name _____ Date of Birth _____ Phone Number _____

Patient/Partner Name _____ Date of Birth _____Phone Number _____

Address _____ City, State, Zip _____

I AUTHORIZE OREGON REPRODUCTIVE MEDICINE TO OBTAIN MY RECORDS FROM:

Name of Provider _____ Clinic Name _____
Address _____ City, State, Zip _____
Fax Number _____Phone Number _____

Type of records to be released:

☐ All Records

☐ Only the Following Records:

- ☐ Physician Consult Notes
- ☐ Treatment Records
- ☐ Embryology Reports
- ☐ Operative Reports
- ☐ Laboratory Reports
- ☐ Ultrasound Reports
- ☐ Hysterosalpingogram (HSG) Report
- ☐ Semen analysis and/or antisperm antibody testing
- ☐ Most Recent Physical and Pap
- ☐ Most Recent Mammogram
- ☐ Other: _____

Purpose of Request:
☐ Treatment/Consultation ☐ Patient Request ☐ Billing/Insurance Other: _____

Certain protected or sensitive information cannot be released without specific authorization as required by State/Federal law. I understand that this information will be disclosed if I **place my initials** in the applicable space next to the type of information.

_____ _____ HIV/AIDS Information
Patient Partner

_____ _____ Genetic Testing Information
Patient Partner

_____ _____ Mental Health Information
Patient Partner

_____ _____ Drug/Alcohol Diagnosis/Treatment
Patient Partner

Duration and Right to Revoke Authorization: This authorization can be revoked at any time by submitting a notice in writing. Such revocation would be effective upon receipt. Unless revoked, this authorization is valid for both the patient and the patient's partner/spouse.
Redisclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal HIPPA regulations.
I understand that ORM/RML will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

_____ _____
Patient Signature Date

_____ _____
Patient/Partner Signature Date

Records Needed By: _____