Oregon Reproductive Medicine

Authorization to Release Medical Records from ORM to Self/Provider

Hard copy releases can be faxed to 503.208.2741 or upload to your ORM Patient Portal

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 SEND MY RECORDS TO:

Name of Provider _____ Clinic Name _____

Address _____ City, State, Zip _____

Fax Number _____ Phone Number _____

Self via: ☐ Mail to home address above ☐ Upload to my Patient Portal ☐ Email: _____

☐ Fax: _____

Type of records to be released:

☐ Physician Consult Notes ☐ Treatment Records ☐ Embryology Reports

☐ Operative Reports ☐ Laboratory Reports ☐ Ultrasound Reports

☐ Hysterosalpinogram (HSG) Report ☐ Semen Analysis/Antisperm Antibody Testing

☐ All Records ☐ 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/my partner place my/our initials in the applicable space next to the type of information.

_____ _____ HIV/AIDS Information _____ _____ Genetic Testing Information

Patient Partner Patient Partner

_____ _____ Drug/Alcohol Diagnosis/Treatment (*includes only the required psychological evaluation/consult held by the Licensed Psychologists of ORM*)

Patient Partner

_____ _____ Mental Health Information (*includes only the required psychological evaluation/consult held by the Licensed Psychologists of ORM*)

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

_____ _____

Partner/Spouse Signature Date

Phone: 503.274.4994 Fax: 503.208.2741