

Synergy Women's Health Care, LLC
2250 NW Flanders, Ste 205
Portland, OR 97210
Phone (503) 227-4050
Fax (503) 477-7673
www.synergypdx.com

Amy R. Bruner, MD
Laura Greenberg, MD
Sally Holtzman, MD
Laura Korman, MD
Wendy Vannoy, ND
Lee Hullender Rubin, LAc
Sheryl Horwitz, WHNP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the use and/or disclosure of my protected health information (medical records) described below:

PATIENT NAME: _____ DOB: _____

I authorize the following to RELEASE my protected health information (Please include name of facility/provider, address, phone/fax number):

I authorize the following to RECEIVE my protected health information (Please include name of facility/provider, address, phone/fax number):

The purpose of the release is:

___ At the request of individual ___ Diagnostic Evaluation ___ Coordination of Care ___ Change of Physician

___ Other: _____

The following information may be released:

All medical records ___ Labs ___ Problem list ___ Imaging ___ Medical Summary

___ Progress Notes ___ Medication Records ___ Operative reports ___ Pathology

___ Other _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

HIV/AIDS information Genetic testing information Mental Health information

Drugs/alcohol diagnosis, treatment, or referral information

Please send my records for the following Dates of service: From: _____ through _____.

- ✓ This authorization will expire 180 days from the date signed.
- ✓ You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any disclosures already made with your permission. To revoke your records release with this authorization, please send a written statement to our clinic at 2250 NW Flanders St., Ste. 205, that identifies the date you signed the authorization, the recipient of the information in the authorization and state you are revoking this authorization.

I have reviewed and I understand this authorization. I also, understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

(Signature of patient or representative)

Relationship (if signed by representative)

(Date)

Updated 09/16