EAST CASCADE WOMEN'S GROUP

Bend Office:
2400 NE Neff Rd., Ste. A
Bend, OR 97701

Redmond Office:
865 SW Veterans Way
Redmond, OR 97756

Phone: 541.389.3300
Fax: 541.389.8115
Email: records@ecwg.net

Authorization for the Release of Medical Records

Where are the records being released from?

Facility/Provider Name: Facility Fax#:

Address: City: State: Facility Phone#:

Patient Information:

Name: DOB:

Email:

Address:

City: State: Zip:

Phone#:

Where are the records being sent?

Name: East Cascade Women's Group

Email: records@ecwg.net

Address: 2400 NE Neff Rd. Suite A

City: Bend State: OR Zip: 97701

Phone#: 541.389.3300 Fax#: 541.389.8115

What would you like released? Check all that apply.

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ Psychological/Psychiatric, if any

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records ☐ Substance Abuse, if any

☐ Last Two Years of Records ☐ Dates _____ to _____

☐ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like **excluded.**

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize East Cascade Women's Group to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations.
I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient: