RELEASE OF MEDICAL INFORMATION

OHSU Fertility Consultants
3303 SW Bond Avenue CH10F
Portland, OR 97239-4501
503-418-3700, Fax 503-418-375

Patient's Name:_____
Patient's Phone #:_____
Date of Birth: ___ / ___ / _____
Medical Record #:_____

I authorize OHSU Fertility consultants to release a copy of the medical information

for _____
(Name of Patient)

to _____.
(Name and Address of Recipient)

This information will be used on my behalf for the following purpose(s): _____

_____.

As indicated below, I authorize the release of the following medical records:

_____ Andrology Laboratory Records
_____ Embryology Laboratory Records
_____ Embryo Cryopreservation Records
_____ OHSU Fertility Consultants Medical Records

RELEASE OF THE FOLLOWING RECORDS AND INFORMATION REQUIRES SPECIFIC AUTHORIZATION. INITIALS ARE REQUIRED, AND THE RECORDS CANNOT BE RELEASED WITHOUT THIS SPECIFIC AUTHORIZATION:

_____ HIV Related Records
_____ Mental Health Information
_____ Genetic Testing Information (Must be initialed to be included in other documents.)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this authorization will expire one year from the date that it is signed or shall remain in effect for the period reasonably needed to complete a request for information.

_____ ___ / ___ / _____
Patient Signature Date

NOTARY:

State of _____ County of _____

Signed or attested before me on ___ / ___ / _____

_____
Official Notary Public Signature

My Commission Expires ___ / ___ / _____

IN LIEU OF NOTARY: _____
OHSU Fertility Consultants Clinic Staff Witness