Synergy Women's Health Care, LLC
2525 NW Lovejoy St, Ste 300
Portland OR 97210
Phone: 503-227-4050
Fax: 503-477-7673
www.synergypdx.com

Laura Korman, MD
Michelle Sang, MD
Sheryl Horwitz, WHNP
Sangita Ghimire, WHNP

Former Synergy Provider:_____

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 facility/provider to RELEASE my protected health information:

Synergy Women's Health Care, 2525 NW Lovejoy St, Ste 300, Portland OR 97210, P: 503-227-4050 F: 503-477-7673

I authorize the following facility/provider to RECEIVE my protected health information (enter name, address, phone/fax numbers):

_____

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 mail a written statement to our clinic 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