

## Authorization to Release Medical Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please fill in where you would like to get records from:

\_\_\_\_\_  
(Name of Doctor/ Clinic)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

The purpose of the release is diagnostic evaluation and treatment.

\_\_\_\_\_ Please send all records.

\_\_\_\_\_ Please send only \_\_\_\_\_

Please provide medical information to:

**Randi R. Ledbetter, MD, P.C.**  
**The Menopause Center**  
**9155 S.W. Barnes Rd., Suite #219**  
**Portland, OR 97225**  
**(503) 297-4774 - voice (503) 297-1889 - fax**

I give my permission to fax and/or send electronically. I authorize disclosure of my medical records for the purpose stated above. I further understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. I specifically authorize the release of the following confidential information: HIV test and test results and related information including high risk behavior documentation, drug/alcohol diagnosis, treatment or referral information, mental health treatment information, and genetic information. I have signed my consent (in Dr. Ledbetter's office) authorizing release of information per HIPAA regulations.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Legal Guardian

\_\_\_\_\_  
Date