Ruth Lowengart, MD, MSOM

Orthopedic Medicine and Occupational Health

2627 Siskiyou Blvd., Suite 100
Medford, OR 97504
(541) 776-5111
Fax (541) 857-4469

AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or a person permitted by law to give authorization.

_____I authorize the release of medical information **to/from** Ruth Lowengart, MD **to/from:**

Name of doctor/health care provider:____

Address:____

Phone Number:__________________ **Fax Number:**________________________

This release for medical information is concerning:

Patient Name:____ **DOB:**________________

Reason for releasing medical information:____

By initialing below, I specifically authorize the release of the following information:

______Chart notes from this office
______Imaging results, x-ray, nuclear medicine
______Laboratory Reports, Pathology Reports

______HIV Status (Initials Required)

______Outside Provider records, correspondence
______Hospital Records
______EKG, Treadmill, Other________________
______Billing and Insurance Records

_____**All records contained in the medical record**

______**Information regarding drug and/or alcohol treatment** (description of information)

____

This Information is limited to the following time period (not to exceed a five year period)
From:_____________________ to:________________________

This authorization is limited to a worker's compensation claim for injuries sustained on:

____

This authorization may be revoked at any time. Revocation will not affect records released prior to revocation. Unless revoked earlier, this consent will expire 360 days from the date of signing or shall remain in effect for the period of time necessary to complete the medical treatment this authorization supports. Intent to revoke content must be submitted in writing.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/Aids information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

____ ________________________

Signature of patient or representative Date

_______Patient ______Parent ______Guardian ______Other_________________________