REQUEST FOR RELEASE OF MEDICAL RECORDS

I_____, Social Security Number _____, am requesting that the following information be released to Bend Birth Center as soon as possible. I understand that my medical records may contain information regarding sexually transmitted diseases, including HIV/AIDS. Release of this information is voluntary and is protected by state law. I authorize you to release the following information:

PLEASE ONLY CHECK ONE

_____ My medical record, including my past obstetrical records, testing or treatment for sexually transmitted diseases, INCLUDING information pertaining to HIV/AIDS. Please include all laboratory work done.

_____ My current medical record, including my past history, testing or treatment for sexually transmitted diseases, EXCLUDING information pertaining to HIV/AIDS. Please include all laboratory work done.

_____ My medical record, EXCLUDING my past history, testing or treatment done for sexually transmitted diseases, EXCLUDING information pertaining to HIV/AIDS. Please include all laboratory work done.

_____ _____

Patient Signature Date

_____

Patient Date of Birth

Bend Birth Center
61533 Parrell Rd
Bend, OR. 97702
P: 541 749 4660
F: 541 749 2108
(ATTN: JANETTE GYESKY, LM)