



**ANDROLOGY/EMBRYOLOGY
LABORATORY**

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 _____ to release a copy of the medical information
(Name of Hospital/Health Care Provider)

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 SPECIFIC AUTHORIZATION:**

_____ HIV Related Records

_____ Mental Health Information

_____ Genetic Testing Information (Must be initialed to be included in other documents.)

_____ Drug/alcohol diagnosis, treatment or referral information as listed. (Federal Regulation, 42
CFR, Part 2, requires a description of how much and what kind of drug/alcohol information
is to be disclosed.) This drug/alcohol information authorization is limited to the following
information: _____,
and is limited to the following time period: _____.

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.

(Date)

(Signature of Patient or Person Authorized by Law)

(Relationship to Patient)

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