



2190 NE Professional Court,  
Bend, OR 97701  
Phone: 541.382.8622. Fax: 541.383.0021

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

**David B. Redwine, M.D.,P.C..**

**2190 NE Professional Court**

**Bend, OR 97701**

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

- Operative** and **Pathology** reports from all **Pelvic Surgeries**
- Chart notes from most **recent Pelvic Exam**
- Pelvic:** Ultrasounds / MRI / CT / X-Ray (please only send the written report from these tests)
- Other: \_\_\_\_\_

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.