Excellence in Women's Healthcare
Linda Sewell, MD

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: ________________________________ Date of Birth ___/___/____

Social Security # ______/______/_______

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I Authorize: (Person or facility which has health information)	**To release health information to**: (Person or facility to receive health information)
Name: _____________________	Excellence in Women's Healthcare
	Linda Sewell, MD
Address: _____________________	2564 NW Edenbower Blvd, Ste 134
_____________________	Roseburg, OR 97471
_____________________	Phone: 541-492-2350
Phone: _____________________	fax: 541-492-2346
Fax: _____________________	

Please specify the health information you authorize to be released:

Type(s) of health information:
____
____

Specify date(s) of treatment or time period: ____________________________________

Please describe the purpose of this release: _____________________________________

The following information will not be release unless you specifically authorize it by initialing the relevant line(s) below: (initial each)

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.
_____ I specifically authorize the release of HIV/AIDS and sexually transmitted disease test results.
_____ I specifically authorize the release of genetic testing information.

Signature:

_____________________________	________________________	______________
Signature (patient/parent/guardian)	Print Name	Date
_____________________________	________________________	______________
Relationship to (patient/parent/ Guardian/conservator/pt representative Or Interpreter)	Witness (if patient is unable to sign)	Phone number