OREGONNEUROLOGY PC

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ____ Date of Birth: ___/____/_______

I hereby authorize: ____
(fill in name of individual/agency)
____
(fill in address)
____
(city, state, zip code)

to provide records and/or psychiatric information to:

____
(fill in name of individual/agency)
____
(fill in address)
____
(city, state, zip code)

The following information is to be released: (*circle*: History/Physical, Discharge Summary, Labs, X-rays, Scans, other: ____)

For purposes of: (*circle*: Patient Care, Medical Review, Legal Review-indicate type of injury and date, other: ____)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS Information _____ Mental Health Testing _____ Genetic Testing Information
_____ Sexually transmitted disease information _____Drug/alcohol diagnosis, treatment or referral information

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.

You need not sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please send a written statement to Medical Records, Oregon Neurology, 19260 SW 65th Avenue Suite 280, Tualatin, OR 97062 and state that you are revoking this authorization.

Unless revoked, this authorization expires in 180 days or 6 months from the date signed.

I hereby authorize Oregon Neurology, P.C. to either fax or send my records via secure email server (e.g. Patient Portal) _________ *(initial here)*

I have read this authorization and understand it.

Signature: ____

Date: ___/____/_______Relationship to Patient: ____