Eugene Rheumatology

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECT Health INFORMATION

By signing this authorization, I authorize ____ to use and/or disclose certain protected health information (PHI) about me to:

Eugene Rheumatology (fax 541-687-1086)

This authorization permits **Eugene Rheumatology** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be use or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc. below):

_____ Chart Notes　　_____ X-rays　　_____ X-ray Reports
_____ Lab Reports　　_____ Medical History　　_____ ______________________

The information will be used or disclosed for the following purpose:
Continuing care

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 information
_______ Genetic testing 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.

PROVIDER INFORMATION: You do not need to 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. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to our office at 132 East Broadway, ste 830, Eugene Oregon and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires 1 year from sig date (insert either applicable date or event).

Signed by ______________________________　　______________________________
Signature of Patient or Legal Guardian　　Date

______________________________　　______________________________
Print Patients full name　　Date of Birth of Patient

****RELEASE TO US***