_____ DR APPROVED _____ **PAID**

Eugene Rheumatology

132 East Broadway, Suite 830
Eugene, Oregon 97401
Phone (541) 687-0816
Fax (541) 687-1086

Simona Braun MD
Sarah Cassell MD
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECT Health INFORMATION

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

PATIENT NAME: _____

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):

DATE(S) REQUESTED

_____ Chart Note(s) _____ X-ray disc
_____ Lab Report(s) _____ X-rays Report(s)

_____

_____

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

Personal Records

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 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 in 1 year from signature date

I understand and agree that I am financially responsible for the following fee associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is **$35.00 ANNUAL FEE OR A $5.00 ONE TIME FEE** for up to 10 pages **and/or $5 for disc of x-rays.**

The charge for your PHI is the time spent in reviewing your chart and the copying time. This is performed in accordance within the HIPPA guidelines.

Signed by _____ _____
Signature of Patient or Legal Guardian — Date

_____ _____
Print Patients full name — Date of Birth of Patient

*****RELEASE TO PATIENT***