OREGON UROLOGY INSTITUTE
2400 Hartman Lane • Springfield, OR 97477 • Phone: 541-334-3350 • Fax: 541-746-4569

Authorization to Use and Disclose Health Information

Last ____ Middle: _________ First:_____________________

Date of Birth: ______ - ______ - ______ SSN: _________ - ______ - _________

I Authorize Oregon Urology Institute to Obtain/Release Health Care Information:

For **the purpose of Release:** ❑ **Continuation of Care** ❑ **Patient Request**

❑ **To** ❑ **From**

____

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Phone: ________ - ________ - ________ Fax: ________ - ________ - ________

Description or nature of information to be used and/or disclosed: *(check all that apply)*

- ❑ Discharge Summaries
- ❑ History & Physical exams
- ❑ Consultations
- ❑ Operative reports
- ❑ Physician progress notes
- ❑ Nursing notes
- ❑ Clinician office notes
- ❑ Pathology reports
- ❑ Radiology & Imaging reports
- ❑ Laboratory records
- ❑ EKG reports
- ❑ Emergency Room records
- ❑ Medication records
- ❑ Billing statements

Specially Protected Information:
- ❑ Mental health treatment records
- ❑ Drug/Alcohol abuse diagnosis, treatment, & referral records
- ❑ Information on HIV/AIDS/Sexually transmitted diseases
- ❑ Information re: genetic testing (Oregon)

❑ Records for the following dates/treatment:

❑ Other records *(specify)*: ____

❑ **All health records from the above-named entity (including the above Specially Protected Information unless box(es) checked):**

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1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provide covered by Federal or State privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, Genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal or State law may prevent the recipient from re-disclosing this information.
2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purpose of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determination, or if the services related to the information to ne disclosed are performed solely for the purpose of providing that information to someone else.
3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above-named Entity on its designed form. However, any such revocation will not apply to any activity undertaken based on this authorization. Oregon Urology Institutes' Notice of Privacy Practices also describes how to revoke this authorization.
4. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.
5. Return payments to Oregon Urology Institute Billing Department. Medical Records will be released within 30 days of receipt of payment.

UNLESS REVOKED, this authorization is valid for 90 days from the signature date below or for the following time period:

Beginning date: ___________________________ Ending (expiration) date: ___________________________

SIGNATURE: I have read this authorization and I understand it.

____ ____________________

Signature of Patient or Legal/Personal Representative/Relationship to patient **Date**