Willamette Urology, PC
2973 12th Street SE Salem OR 97302
Phone: 503-561-7100 Fax: 503-561-7124

Authorization to Use and Disclose Protected Health Information Form

Last Name:_____ First Name: _____ Middle:___ Date of Birth: ___/___/___

Address:_____ Phone: _____

I hereby authorize:	**To provide medical information to:**
_____ (*name of individual, facility, agency*)	_____ (*name of individual, facility, agency*)
_____ (*address*)	_____ (*address*)
_____ (*city, state, zip*)	_____ (*city, state, zip*)
Phone:_____ Fax: _____	Phone:_____ Fax:_____

Purpose of request: ____ At the request of the patient ____Treatment or Consultation ____Billing or claims payment

Other:_____

Type of information to be released: ____ chart notes _____Consultation reports _____ Operative reports

_____ Laboratory test reports _____Imaging reports _____ History & physical _____ ER/ Hospital reports

Time Period:_____ All Records or _____
(*from*) (*to*)

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 _____ Drug/alcohol diagnosis, treatment, or referral information

_____ Mental health information _____ Genetic testing 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 purpose described in this written authorization. The only exception is when 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: Medical Records at Willamette Urology, P.C., 2973 12th Street Se Salem, OR 97302 and state that you are revoking this authorization.

I HAVE READ THIS AUTHORIZATION AND I UNDERSTAND IT. Unless revoked, this authorization expires: _____ (*insert either applicable date or event*).

SIGNATURE: _____ DATE:_____ Relationship (if not patient):_____