



AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Date of Birth: _____
(PLEASE PRINT)

I, _____

voluntarily authorize the records custodian of:

to disclose a copy of all health information to:

I authorize The Doctors' Clinic, LLP to disclose the following records:

- 5 years of medical records Lab reports Billing statements
- Chart notes Pathology reports Other: _____
- Immunization records Diagnostic reports

For the time period from _____ to _____

Is this request for a transfer of care? Yes _____ No _____

Please note any category of records that you do not wish to be disclosed: _____

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 **only** if I place my **initials** in the applicable space next to the type of information.

- _____ HIV/AIDS information _____ Mental Health Information
- _____ Genetic Testing Information _____ Sexually transmitted disease information
- _____ Alcohol/Chemical dependency 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 law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

PATIENT INFORMATION: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the continuation or quality of my treatment or reimbursement for services by my healthcare provider. Any use or disclosure already made with your permission cannot be undone. You may revoke this authorization by sending your written request to: Records Custodian, The Doctors' Clinic, 5050 Skyline Village Loop S, Salem, OR 97306.

I have read this authorization and I understand it.

By: _____ Date: _____
(SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:

Unless revoked, this authorization expires: _____