MEDFORD NEUROLOGICAL & SPINE CLINIC

2900 STATE STREET • Medford, OR 97504-8456

Telephone (541) 779-1672 Fax (541) 779-0986

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION: I authorize:____

(Name, phone, fax, address of person/entity disclosing information)

to use and disclose a copy of the specific health information described below regarding:

____ Date of Birth:________________

(Name of individual)

consisting of:____

(Describe information to be used/disclosed)

to:____

(Name, phone, fax, address of recipient or recipients)

for the purpose of:____

(Describe each purpose of disclosure)

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

_____ Genetic Testing Information

_____ Mail records _____ FAX records

_____ Mental Health 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. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to the privacy officer at Medford Neurological & Spine Clinic and state that you are revoking this authorization.

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

Unless revoked, this authorization expires:____

(Insert either applicable date or event)

By:____Date:________________

(Individual or personal representative)

Description of personal representative's authority:____