AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I Authorize Name & Address of health care provider:
Brent K. Evetts, MD
19875 SW 65th Ave Ste 260 Tualatin, OR 97062
PH: 503-691-1743 Fax: 503-691-0983

To use/disclose medical information to:
_____
_____
_____

for the purpose of:_____
(Describe each purpose of disclosure)

Name of Patient _____ Date of Birth _____

Other Names Used: _____ Phone # of Patient or Personal Rep._____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist.

Specify Below:

____ Clinician office chart notes ____ Transcribed hospital reports ____ Laboratory reports
____ Emergency & Urgent care records ____ Diagnostic Imaging reports ____ Pathology reports
____ Other: _____

____ Please send the entire medical record (all information) to the above named recipient.

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 _____ Sexually transmitted disease information
_____ Alcohol/chemical dependency diagnosis, treatment, or referral information

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to (Privacy Officer/Office Manager at 19875 SW 65th Ave Ste 260 Tualatin, OR 97062) that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date:_____
(Patient)
By:_____ Date:_____
(Patient representative)
Description of Representative's Authority:_____