

Authorization to Obtain Protected Health Information

I, _____, authorize _____
Name of Patient Physician or Organization other than Primary Care Provider

Address, City, State, Zip of Authorized Physician or Organization

to release the following protected health information to Dr. _____
at Urologic Consultants, PC, 9135 SW Barnes Rd, Ste 663, Portland, Oregon, 97225.
Phone: 503-297-1078 Fax: 503-292-2176

Information to be used or disclosed (please check all that apply):

Chart notes Lab notes Operative reports Medication records X-ray Entire record Other _____

This protected health information is being used or disclosed for the following purposes:

(Optional)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

**Shelley Brown, Clinic Administrator
Urologic Consultants, PC
9135 SW Barnes Rd, Ste 663
Portland Oregon 97225**

I understand that a revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative