



Please note: If records are more than 20 pages, please mail hard copy or send on encrypted CD/flashdrive.

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Women's Health Center of Southern Oregon, P.C.
1075 SW Grandview Ave., Ste. 200
Grants Pass, OR 97527
Phone: (541) 479-8363 Fax: (541) 476-2841

AUTHORIZATION I authorize: \_\_\_\_\_
(Name of person/entity disclosing information)

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

\_\_\_\_\_ (Name of individual) \_\_\_\_\_ (D.O.B.)

Consisting of: \_\_\_\_\_
(Describe information to be used/ disclosed)

to: \_\_\_\_\_
(Name and 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
\_\_\_\_\_ Mental Health information
\_\_\_\_\_ Genetic testing information
\_\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure 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. The only exception is when a 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 the Privacy Officer at Women's Health Center at the address listed above and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked in writing, this authorization expires \_\_\_\_\_ (insert date or event). If no date or event is indicated, this Authorization will expire in five (5) years from date of signing.

BY: \_\_\_\_\_
(Individual or personal representative)

DATE: \_\_\_\_\_