RECORDS RELEASE AUTHORIZATION

A health care provider may use an authorization that contains the following provisions in accordance with ORS 192.559:

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: Northwest Gynecology Associates to use and disclose a copy of the specific health information described below regarding:

_____

(Name of Individual) `` `(Date of Birth)

consisting of your medical records to:

_____

(Medical Practice name and fax number)

OR:

_____

(Patient's email address for HIPPA compliant delivery)

for the purpose of continuation of care due to closure of medical practice

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 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.

I have read this authorization, and I understand it.

_____

Signature of Individual or Personal Representative Date

Description of personal representative's authority:

_____

_____