ROGUE VALLEY UROLOGY
PHYSICIANS AND SURGEONS, PC

www.RogueValleyUrology.com

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____
Address: _____
_____
Telephone: _____

Other names under which the Patient has been treated: _____

I authorize _____ and its employees, agents or associated healthcare practitioners ("PROVIDER") to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** PROVIDER may use or disclose information relating to healthcare provided during the following time period:
   - ☐ Anytime.
   - ☐ Healthcare provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** PROVIDER may use or disclose the following type(s) of information:
   - ☐ Any information concerning the Patient's healthcare or payment during the relevant time period.
   - ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
     - ☐ Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc*.)
     - ☐ Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc*.)
     - ☐ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: _____

3. **Persons to Whom Disclosure Allowed.** PROVIDER may disclose the information to the following entity(ies):
   Name or description: _____
   Address: _____
   _____
   Phone number: _____
   Fax number: _____

4. **Purpose.** PROVIDER may use or disclose the information for the following purpose(s):
   - ☐ The disclosure is made at the Patient's request.
   - ☐ Continuation of care.
   - ☐ Transfer of care.
   - ☐ For a potential or pending legal proceeding.
   - ☐ For marketing. PROVIDER *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.
   - ☐ Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Rogue Valley Urology

I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless (1) the purpose for PROVIDER's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by PROVIDER pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: _____.
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____
Signature Date

_____
Authority or relationship to the Patient

** Give a copy of the authorization to the Patient or personal representative.*