Oregon Urology Alliance

Authorization for the Release of Medical Records

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient name: _____ Date of Birth: _____
Last First Middle

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone#: _____

Please indicate the doctor's office where you want the medical records sent:

Doctor's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax #: _____

If you do not want certain portions of your medical records released, please check the categories listed below you would like EXCLUDED:

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Transfer of Care

****Per HIPAA 45 CFR 164.524, you may be charged a reasonable fee for reproducing medical records. Fees are non-refundable once services are rendered. Payment is due on receipt of the invoice. ****

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient Signature

_____
Date