OREGON UROLOGY ALLIANCE
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Authorization for Disclosure/Release of Medical Records

Patient Name: _____Date of Birth:_____

Please **circle** one of the following: **Receiving** or **Releasing** of protected health information.

I hereby authorize the office of Oregon Urology Alliance to **Receive** or **Release** my protected health information via mail, fax, phone, or in person to/from:

_____

_____

All medical information pertaining to examination or treatment of myself including alcohol, drug abuse, HIV/AIDS-including HIV testing, and mental health records unless specifically stated below:

Exceptions to the above are:

_____

Please initial the space below. I specifically authorize the release/receiving of the following medical records, if such records exist:

_____ Laboratory Reports _____Office Chart Notes inc. History & Physicals

_____ Pathology Reports _____ Consultation Notes

_____ Diagnostic Imaging Reports

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete request.

_____ _____

Signature of patient or authorized person Date