OREGON UROLOGY ALLIANCE

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Authorization for Disclosure/Release of Medical Records

Patient Name: ___________________________________ Date of Birth:__________________

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

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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. Exceptions are:

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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.

____ __________

Signature of patient or person authorized by law to act on the patient's behalf Today's Date