Patient Authorization to Disclose Health Information

Patient Name _____ Date of Birth _____ Telephone # _____

I authorize:

Facility/Person _____ Phone # _____ Fax # _____

Street Address _____ City/State/Zip _____

Provide Information To:

BRUNE DERMATOLOGY
1740 NW 9th Street
Corvallis, OR 97330
Ph: 541-230-1350
Fax: 541-207-3477

The information will be used on my behalf for the following purpose(s): _____

Information to Be Disclosed:

- ❑ Entire Chart
- ❑ History & Physical
- ❑ Medications / Therapy
- ❑ Lab / Pathology / ECG Reports
- ❑ Imaging Reports
- ❑ All Clinician(s) Chart Notes
- ❑ Immunizations
- ❑ Problem List
- ❑ Operative Reports
- ❑ Other Records as Specified: _____
- ❑ **Specific Dates of Treatment:** _____

By initialing in the spaces below, I authorize disclosure of the following information:

_____ HIV / AIDS Related Information
_____ Psychotherapy / Mental Health Program Notes
_____ Genetic Testing Information
_____ Drug / Alcohol Addiction Program Records

Disclosure of above information is limited to the following:

- ❑ Time Period: _____
- ❑ Treatment Dates: _____

_____ DO NOT NEED RELEASE OF THE ABOVE RECORDS

- I understand that this authorization will automatically expire in 180 days from the date of my signature or on (date): _____
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Brune Dermatology, LLC. I understand that the revocation will not apply to information that has already been disclosed in response to and in reliance on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that once the information is disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and the information may not be protected by federal privacy regulations. However, I also understand that federal or state law may restrict re-disclosure of HIV / AIDS related information, psychotherapy / mental health program notes, genetic testing information, and drug / alcohol addiction program records.
- I understand that I need not sign this form in order to ensure health care treatment, payment, and enrollment in my health plan, or eligibility for benefits.
- I understand that I will be given a copy of this authorization form after signing.

Signature of patient _____ *Date* _____

Signature of person authorized by law to sign for patient _____ *Relationship to patient* _____

PRINT **EMAIL**