SONSA
SOUTHERN OREGON NEUROSURGICAL & SPINE ASSOCIATES, PC.
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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:______________________________ DOB:______________
PHONE NO:______________________________
ADDRESS:______________________________

INFORMATION TO BE RELEASED FROM:	PLEASE SEND RECORDS TO:
NAME OF CLINIC:____________________	NAME:____________________
NAME OF PHYSICIAN:____________________	____________________
ADDRESS:____________________	ADDRESS:____________________
____________________	____________________
PHONE:____________________	PHONE :____________________
FAX :____________________	FAX:____________________

RECORDS TO BE RELEASED:______________________________

FOR THE PURPOSE OF:______________________________

☐ Mail Records ☐ Fax Records ☐ Pick up ☐ Paper Copy ☐ Records on CD (available for patient copy only)

If the information to be disclosed contains any of the types or records/information listed below, additional laws relating to the use and disclosure of the information may apply**. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.**

☐ HIV/AIDS ☐ Mental Health Information ☐ Genetic Testing ☐ Drugs/Alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION: You do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Southern Oregon Neurosurgical and Spine Associates and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. **I am aware a $25 fee may apply to this request** (payable in check or cash only). Unless revoked, this authorization will expire 180 days from the date of signature.

Signed by:______________________________ Date:______________________

Description of personal representative's authority (if not signed by patient).______________________
**PLEASE NOTE. Power of Attorney or Guardianship paperwork may be required in order to accept a signature other than the patient's.

Witness Initials:__________________