CATARACT & LASER
INSTITUTE
Of Southern Oregon, P.C.

AUTHORIZATION TO RECEIVE / DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	**Date of Birth**
Patient Address	**City / State / Zip**

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION FROM:

Name of Person or Organization **Releasing** Information	
Address of Person / Organization	
Phone Number	Fax Number

TO RELEASE MY INFORMATION TO:

Name of Person or Organization **Receiving** Information	
Address of Person / Organization	
Phone Number	Fax Number
Email Address:	

Sent Via: ☐ **Mail** ☐ **Fax** ☐ **Email Address** ***(Sent via encrypted email unless requested otherwise)***

Please note if PHI (Personal Health Information) is sent using unencrypted email the information is at risk for interception by an unknown party while in transit

INFORMATION TO BE RELEASED:

☐ Complete Medical Record

☐ Medical Records from Specific Dates of Service *(Please list)*:
From: To:

☐ Other *(Please list)*:

I additionally authorize the information listed below to be used, disclosed or received by placing my initials next to listed information:

_____ HIV/AIDS Related Records _____ Mental Health Related Records
_____Genetic Testing Information _____ Alcohol and Drug *(Also Prescribed)* Related Information

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure and may no longer be protected by federal state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect a copy of protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization will remain in effect for one calendar year from the date of completion in accordance to the data contained herein.

Signature of Patient or Representative **Date**

_____

Description of Representative's Authority *(Attach Supporting Documents If Applicable)*

Tina Rutar, M.D. // Justin M. Spaulding, D.O. // Allison Jarstad, D.O. // Clara M. Castillejo Becerra, M.D.
1408 East Barnett Road, Medford, OR 97504-8279 P: 541-779-2020 // F: 541-770-6838