REQUEST FOR
USE/DISCLOSURE HEALTH INFORMATION

I authorize Center for Genetics and Maternal-Fetal Medicine to use and disclose a copy of the specific health information described below regarding:

Name of Patient: _____

Also Known As: _____

Date of Birth: _____ Date of Death: _____

Social Security Number: _____ Patient ID Number: _____

Records released from: Facility: _____ Fax Number: _____

Address: Address: _____ Phone Number: _____

Describe and Initial what information is to be disclosed and the purpose: _____

__Consult notes __Laboratory Results (including DNA and Chromosomal) __Pathology Reports

__HIV __Mental Health __Drugs/Alcohol

—Other _____

Your Health care and payment for that health care cannot be conditional upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or

(2) For the Purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use of disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Manuel Williams 4780 Village Plaza Loop Suite 220 Eugene Oregon 97401 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of _____(date), 180 days form the date of signing, or the end of the period reasonable need to complete the disclosure for the above state purpose.

Records Released To: **Center for Genetics and Maternal-Fetal Medicine**
3355 RiverBend Drive, Suite 210
Springfield, OR 97477
Ph: 541-349-7600
☐ Fax Number: 541-686-8330
☐

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
(Patient)

OR

By: _____ Date: _____
(Patient Representative)
Description of Representative's Authority _____

(For internal use - Center for Genetics Patient): _____