Lee Gynecology
9555 SW Barnes Road, Suite 360
Portland, OR 97225

Authorization to Use/Disclose Protected Health Information

I authorize **Michael J. Lee, M**D to: (select one)
__ receive a copy of my health information **for the past _____** from another clinic or individual.

__ send a copy of my health information to another clinic or individual.

to/from: _____
NAME & ADDRESS OF RECIPIENT OR RECIPIENTS

_____

Information consists of (check all that apply):
__ Entire Medical Record __ Lab/Pathology Reports __ Cytology/Pap Report
__ X-ray/Imaging Reports __ Immunization Records __ Other (Please explain):

for the purpose of: __ Continuing Care __ Transfer of Care __ Other

If the information to be disclosed contains any of the types of records or 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 information
___ Sexually transmitted disease information
___ Mental health information
___ Genetic testing information
___ Alcohol/chemical dependency diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal restricts redisclosure of alcohol and chemical dependency diagnosis, treatment, or referral information and specifically requires my authorization prior to redisclosure.

PATIENT INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for for services. The only circumstance when refusal to sign means you will not receive health care services is if those services represent research-related treatment and authorization is necessary to participate in the study and to receive research-related treatment.

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 Lee Gynecology at the address above and state that you are revoking this authorization.

Signature: I have read this authorization and I understand it.

By: _____ Date: _____
PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

_____ Date of Birth: _____
PATIENT NAME (PRINTED)