

**BENSON HEALTH CLINIC AUTHORIZATION  
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION**

66 Club Rd #160 Eugene, OR 97401    Ph: 541-345-1722    F: 541-485-7049

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Release PHI to: \_\_\_\_\_

OR Obtain PHI from: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Consisting of:**

- Hospital Records     Medical Records Needed for Continuity of Care     Most Recent \_\_\_ Year History  
 Laboratory Reports     Pathology Report     Diagnostic imaging reports     Physical Therapy Records  
 Emergency and Urgent Care Records     Billing Statements     Chart Notes/Progress Sheets

This authorization is limited to the following treatment \_\_\_\_\_

This authorization is limited to the following time period \_\_\_\_\_

For the purpose of:  Transfer of Primary Care    OR     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    \_\_\_\_ Mental health information    \_\_\_\_ Genetic information  
\_\_\_\_ Drug/alcohol 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 or state law may restrict redisclosure 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 the authorization 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 Benson Health Clinic, PO Box 70779 Springfield, OR 97475 and state that you are revoking this authorization

**I have read this authorization and understand it.**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

By: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Unless revoked this authorization expires: \_\_\_\_\_