

AUTHORIZATION TO USE/DISCLOSE  
PROTECTED HEALTH INFORMATION  
THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID.

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*Patient Name*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*Date of Birth*

**I AUTHORIZE:**

Klein Dermatology & Associates  
5200 SW Meadows Road, Suite 250  
Lake Oswego, Oregon 97035  
Phone: (503) 445-2200  
Fax: (503) 445-2201

**TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:**

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*Practice/Physician Name*

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***Fax or Address***  
**FOR THE PURPOSE OF:**

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*Describe each purpose of use/disclosure*

My protected health information may include medical records, emergency and urgent care records, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, pathology reports, and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

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

- \_\_\_\_\_ **Cosmetic** information and related records
- \_\_\_\_\_ HIV/AIDS test or result information and related records
- \_\_\_\_\_ Mental health information and related records
- \_\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information and related records

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 test or result information, mental health information and drug/alcohol diagnosis treatment or referral information.

**I have reviewed and understand this authorization.**

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*Patient/Guardian Signature*

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*Today's Date*

*This authorization expires 2 years from the date of signature unless otherwise specified.*