Northwest Urology LLC

Urology

James Bresee, MD
Laura Gordon, MD
Daniel Janoff, MD
Jeffrey La Rochelle, MD
Michael Lavelle, MD
Bruce Lowe, MD
Stanley Myers, MD
Thomas Pitre, MD
Brian Shaffer, MD
Sara Spettel, MD
David Staneck, MD
James Tycast, MD
Jennifer Botelho, MPAS
Mandy Williams, PA-C

Pediatric Urology

Daniel Hirselj, MD
David Lashley, MD, FAAP
Kelly Bartholomew, PA-C

Authorization to Disclose Protected Health Information

This form allows your health care providers to disclose your health information to our clinic.

Patient Name: _____ **Date of Birth:**_____
Previous Name: _____ **Social Security (last 4): XXX-XX-**_____

I request and authorize: **Provider/Facility Name/Individual**:_____

Complete address: _____

Phone: _____ ***Fax***: _____

to release protected healthcare information of the above named patient to **NW Urology LLC** for the following purpose: ☐Continuation/Transfer of Care ☐Legal ☐Personal ☐Insurance ☐Other: _____

Please fax or mail records to the following NW Urology location (circle one):

For patients seen at:
St. Vincent
9135 SW Barnes Rd Suite 663
Portland, OR 97225
Phone: (503) 297-1078 **Fax**: (503) 292-2176

For patients seen at:
NW Portland, Peterkort, or Vancouver
2230 NW Pettygrove, Ste. 210
Portland, OR 97210
Phone: (503) 223-6223 **Fax**: (503) 223-3665

For patients seen at:
Sherwood, Newberg, or McMinnville
2435 NE Cumulus Ave., Ste. E
McMinnville, OR 97128
Phone: (503) 435-2561 **Fax**: (503) 434-8203

Information to be used or disclosed:

- ☐ **Entire Medical Record**
- ☐ Radiology Report(s)
- ☐ Other_____
- ☐ Pertinent Records (last 2 years)
- ☐ Laboratory/Pathology Report(s)

Date Range: _____-_____

SPECIALLY PROTECTED RECORDS

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 the information below 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 Testing Information

_____ Drug/Alcohol Diagnosis, treatment, or referral

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Note: Unless revoked, this authorization will expire one year from date of signing.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Printed Name