

Yamhill Valley Dermatology

Richard I. Ecker, M.D.

Main Office: 706 N.E. Evans Street; McMinnville, OR 97128

Phone: 503-472-1405 or 1-866-661-0319 Fax: 503-434-5950

Satellite Office: 310 Villa Road, Suite 106; Newberg, OR 97132 Phone: 503-538-0668

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____ to use and disclose a copy of the specific health and
(Name of physician/physician group)

medical information described below regarding: _____ consisting
(Name of patient)

of: _____ to: _____
(Describe information to be used/disclosed) (Name & address of recipient or class of recipients)

for the purpose of: _____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for that health care cannot be conditioned 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 or 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 the Medical Records department at Yamhill Valley Dermatology; 706 NE Evans Street; McMinnville, OR 97128 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.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

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: _____
(Patient)

Date: _____

Date of Birth: _____

SSN: _____

-OR-

By: _____
(Patient representative)

Date: _____

Description of Representative's Authority: _____