ROBERT P. SOTTA, M.D.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, (name of patient)_____DOB:_____SSN:_____

Authorize Dr. Robert Sotta to use and/or disclose my health information as identified below to:

_____

_____

for the following purpose(s): ( ) patient care ( ) patient request

( ) other:_____

By checking the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____Transcribed operative reports

_____Diagnostic imaging reports

_____Clinician office chart notes

_____Laboratory reports

_____Pathology reports

_____Emergency and urgent care records

_____Billing statements

_____X-rays, MRI, CAT Scan Films

The following items must be initialed to be included in the use or disclosure of other health information:

_____*HIV/AIDS related health information and/or records

_____*Mental health information and/or records

_____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and whit kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____

I understand that I may revoke this authorization at any time by giving written notice to Robert P. Sotta, M.D. **Unless revoked earlier, this authorization will expire 180 days from the date of signing** or upon (insert applicable date or event of expiration)_____.

_____ _____

Signature of individual or individual's legal representative **Date**

_____ _____

Print name of legal representative (if applicable) Relationship of legal representative to individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative)

PO Box 2886 Oregon City OR 97045