Auburn Urogynecology and Women's Health
11795 Education Street, Ste. 222
Auburn, CA 95602
Phone: (530) 886-6660 FAX: (530) 886-6656

Authorization to use or disclose protected health information

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient name:	DOB:	SSN:
Address (street, city, zip)		Telephone:

Send medical records: TO FROM

Auburn Urogynecology and Women's Health
James S. Dunn, Jr. MD
11795 Education Street, Ste. 222
Auburn, CA 95602
Phone: (530) 886-6660 Fax: (530) 886-6656

Send medical records: TO FROM

Circle One:
Physician/Clinic/Self:____
Address:____
Phone:______________________ Fax:________________________

Reason: Change of Insurance Personal Transfer of Care
Moving out of area Legal Other:______________________

The following information to be disclosed: (check all that apply)
Office Visits Lab results X-ray/Imaging Other:______________________
Date range:____________________

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on the authorization.
Other rights: I understand the authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: unless otherwise revoked, this authorization will expire on the following date, event, or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in six months)

______________________________ **Date:**______________
Signature of patient or legal representative

***Unless otherwise stated, the fee for processing the release of medical records is as follows: 1-12 pages $15 and 13-25 pages $25 (applies to records going directly to patient).

If signed by a legal representative, relationship to patient: ______________________________

1/2021 (Office Use) Athena ID:_______