Hung D. Tran, M.D. LLC
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Salem, OR 97301-3907

Phone: 503-585-7454
Fax: 503-585-9254

AUTHORIZATION to USE/DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Alias/Maiden: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

I authorize **Hung D. Tran, M.D.** to:

(Initial→) _____ release information to: and/or **(Initial→)** _____ obtain information from:

_____
Name of Physician, Clinic, Hospital, Person

_____
Address, City, State, Zip Code

_____ _____
Phone Number Fax Number

Specifically, I authorize the exchange of the following confidential information by my **INITIALS:**

(Initial→) _____ Mental health information:

(Initial→) _____ Other:

(Initial→) _____ Drug/Alcohol Information

(Initial→) _____ HIV tests, results, & related information

PLEASE SEND:
(for MD use)

For the purpose of: [ ] Change of Physician [ ] Medical care [ ] Legal Reasons [ ] Self use (Fee for this)
[ ] Other (Please Specify) _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization
2) You may inspect a copy of the protected health information to be used or disclosed
3) You may refuse to sign this Authorization, and
4) We must provide you with a copy of the signed authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. By signing this Authorization, you are directing us to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that we do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.

I 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.

_____/_____/_____ _____
(MM) (DD) (YYYY) Signature of patient or of Representative authorized by law

Description of Representative's Authority: _____