



**AUTHORIZATION TO LEAVE VOICEMAIL OR MESSAGE**

- Cardiovascular Medicine
- Ear, Nose & Throat
- Gastroenterology
- Gastrointestinal and Minimally Invasive Surgery (GMIS)
- Imaging Services
- Neurology
- NW Surgical Associates
- Podiatry
- Pulmonary, Critical Care and Sleep Medicine
- Radiation Oncology
- Thoracic & Cardiovascular Surgery
- Urology
- Westside Surgical Specialists

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize medical providers and personnel of The Oregon Clinic to leave a voicemail or message at the phone number listed below. I understand this voicemail or message may contain my protected health information.

Voicemail can be left at this phone number: \_\_\_\_\_

A message for me may be left at this number with: \_\_\_\_\_

(Relationship) \_\_\_\_\_. I understand this message may contain my protected health information.

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

- \_\_\_ Information regarding the patient's diagnosis and treatment for HIV/AIDS
- \_\_\_ Psychotherapy notes from a Psychiatrist or Psychotherapist
- \_\_\_ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from \_\_\_\_\_ until \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires.

- Unless specified above, this authorization will expire 7' 0 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Name of Patient/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority