MAURICE COLLADA, JR., M.D., P.C.

Diplomate American Board of Neurological Surgery
Physician and Surgeon

1344 Liberty Street South East
Salem, Oregon 97302
Phone (503) 581-5517
Fax (503) 581-6341

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

The following individual has requested that his or her relevant medical records be released as forwarded:

Patient Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

DOB: ______________________________

☐ From: Maurice Collada, Jr. M.D.
☐ To: 1344 Liberty ST SE
Salem, Oregon 97302

☐ From:
____
____
____

☐ To:
____
____
____

☐ Entire Records or

☐ Operative Reports
☐ Pathology Reports
☐ ECG Reports
☐ X-Ray Reports

☐ Laboratory Reports
☐ Discharge Summaries
☐ Consultations
☐ Progress Reports

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

__________ Alcohol/chemical dependency diagnosis, treatment, or referral information
__________ Genetic testing information
__________ HIV/AIDS tests, results and treatment
__________ Psychiatric or mental illness diagnosis and treatment
__________ Sexually transmitted disease information

I hereby authorize the release of my medical records to the party indicated above. This release expires one year from today, but I understand that I may revoke it by written request at any time.

______________________________ ______________
Signature (parent or legal guardian of patient may sign if pt is unable) Date

______________________________ ______________
Signature of Witness Date