Kuether Brain and Spine
Todd Kuether, MD
501 N. Graham, Bldg 2, Suite 445 Portland, OR 97227
(503) 489-8111 Phone (503) 908-6800 fax
kuetherbrainandspine.com

I, _____ Date of Birth: _____

Authorize:

_____

(Physician, Medical Facility, Spouse/Representative Name, Other)

_____

Address

_____

(City, State, Zip Code)

Phone: Fax:

(area code/phone)

To disclose a copy of the specific health and medical information described below to:

Todd Kuether, MD Kuether Brain and Spine
501 N. Graham, Suite 445 Portland, OR 97227
Phone: (503) 489-8111 Fax: (503) 908-6800

Information to be disclosed (**Initial <u>ONE</u>**):

All Information _____
(Initial)

Specific information noted below _____
(Initial)

Information Requested:

_____

_____

You may inspect or copy the protected health information to be disclosed.

You have the right to revoke this Authorization at any time, provided that you do so in writing and accept 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 for the period reasonable needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected under federal law.

Signature: _____ Date: _____

(Patient or Parent/Guardian (if minor) or P.O.A)