COMMUNITY CANCER CENTER & ROSEBURG ONCOLOGY, PC
PATIENT AUTHORIZATION FOR ELECTRONIC HEALTH RECORDS

To provide better care to its patients **Community Cancer Center and Roseburg Oncology, PC** (collectively referred to as "the Practice") has chosen to participate in an electronic health records system called "Umpqua One Chart." Under this system, each patient has a single, secure set of electronic information that can be accessed by participating physicians and other providers from their offices, urgent care facilities, the emergency room, the hospital, and other locations. Among its many benefits, this system:

- allows immediate access to results of tests, imaging procedures, and other potentially critical information for routine and emergency treatment;
- allows the coordination of prescriptions and care by multiple providers;
- provides Patient and Patient's physicians or other providers with reminders and information from national health treatment databases;
- reduces chances of error and otherwise improves the quality of care Patient receives; and
- helps in the processing of insurance and other claims.

The Practice recognizes the importance of keeping Patient's individual information confidential. Accordingly, Umpqua One Chart has, through contracts and strict rules, limited access to individual information to health care providers and those providing assistance to them, and only for the purposes of providing health care and related activities. Patient privacy is also protected by state and federal law.

I authorize the Practice to include my health information in the Umpqua One Chart for the purpose of providing me with high quality, efficient, and fully informed health care. The health information to be included with my shared health information includes all information in my health records relevant to the above-described purpose, and includes records created by the Practice after the date of this authorization.

By initialing each category, I specifically authorize you to include information about testing, diagnosis, treatment and related information about the following kinds of problems in my records:

_____	HIV/AIDS	_____	Mental Health
_____	Genetic Testing	_____	Drug/Alcohol

Unless revoked earlier, this authorization shall remain in effect until my death.

Note:

(1) *You have the right to revoke this Authorization at any time, provided that you do so in writing. If you do so, we will stop entering your health-related information in Umpqua One Chart. To revoke this authorization, please contact our Privacy Officer;
(2) *We cannot condition our provision of services or treatment to you on the receipt of this signed authorization; and
(3) *I also understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Dated _____, 20___

_____
Patient or Guardian Signature (circle one)

_____
Printed Name of Patient

_____
Printed Name of Above and Relationship