AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ DOB: ____________________

Records To / From (**circle one**) :
Oregon Interventional Pain Consultants
1849 NW Kearney Street #201
Portland, OR 97209
PH (503) 477-5205 FX (888) 972-4730

Records To / From (**circle one**) :
____
____
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____

Consisting of (**please initial**):

_____ Clinical Chart Notes**
_____ Hospital Reports (Operative, H&P Reports)**
_____ Diagnostic Imaging
_____ Entire Medical Record (all information in chart)
_____ Laboratory Reports**
_____ Other** ____________________
____

**Please specify record date span from ____________________ to ____________________

For the purpose of: ______________________________

If the information to be disclosed contains any of the types of 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:

________ HIV/AIDS
________ Mental Health
________ Genetic Testing
________ Drug / Alcohol diagnosis, treatment, or referral.

REDISCLOSURE: I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/ alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are soley for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

REVOCATION: You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke authorization, please send a written statement to Oregon Interventional Pain Consultants & state you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires on: ____________

SIGNATURE: ______________________________ **DATE:** ____________________

(Individual or personal representative)

If Personal representative, description of personal representative's authority: ______________________________

(MUST ALSO ATTACH WRITTEN INSTRUMENT GRANTING AUTHORITY)