THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

Health Information Management
2200 NE Neff Road, Suite 200 | Bend, OR 97701
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# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**Patient Name:** _____ **DOB**_____ **MRN**_____

**Phone:** _____

**May we leave a message?**_____**May we leave message with family?**_____

***I authorize:*** ***(The purpose of this request is at the request of the individual)***

- ❑ The Center
- ❑ Other_____
  (Name/Organization) (Phone) (Fax)

  _____
  (Street Address) (City) (State/Zip)

***To disclose information specific to the following:***

- ❑ Specific Record Type_____
- ❑ Image CD (X-Ray or MRI) List specific body part_____
  ***Images cannot be sent via email.**
- ❑ Other (Specify)_____
- ❑ Specific Dates of Service_____

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 only if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS
_____Mental health information
_____Genetic testing information
_____Drug/Alcohol diagnosis, treatment, or referral information

***Individual or entity authorized to receive my information:*** (please be specific)

**Self** *or* **Other** (please circle) Name/Organization:_____

❑ Fax Address:_____

❑ Mail City/State/Zip:_____

❑ E-mail Fax or E-mail address:_____

**By signing this authorization I understand that:**

- I have the right to revoke this authorization at any time. To revoke this authorization, send a written statement to The Center, Attention: Manager, Health Information Department, 2200 NE Neff Road, Suite 200, Bend OR 97701 and state that you are revoking this authorization. Unless revoked this authorization will expire 180 days from date of signing. Per Federal Law, 45 CFR 164.524, information will be available no later than 30 calendar days from date of request.
- I understand that I may refuse to sign this authorization and refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility of benefits. The only circumstance when refusal to sign will mean I will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law.

Patient Signature X_____ Date_____

*Patient Guardian or Legal Representative X_____ Date_____

*Please note: Copy of proof of legal representation must be provided at the time of request, if not previously on file with The Center

**ID Checked** Yes_____ No_____ Initial_____ **Copied by** Copy Service_____ Staff_____ Initial____