



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB _____ MRN _____

Phone: _____ May we leave a message? Yes No

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

- Fax Name/Organization: _____
- Mail Address: _____
- E-mail City/State/Zip: _____
- 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