AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Name: _____ **Date of Birth:** _____

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: 1) Creating health information about you to be disclosed to a third party; or 2) For the purpose of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any disclosures or uses already made with your permission. To revoke this Authorization, please send a written statement to MR at: 1515 N.W.18th, Suite 300, Portland, Oregon 97209

☐ Please request my records from: Doctor or Clinic: _____

Address/phone: _____

☐ Please send my records to: _____

Address/phone: _____

_____ By initialing I give permission for information to be faxed. Number: _____

All faxed material does include a confidentiality statement, however this does not guarantee confidentiality on the receiving end.

Records I am requesting:

- ☐ Chart notes
- ☐ Imaging reports
- ☐ Labs
- ☐ Complete Medical Chart*
- ☐ Films**
- ☐ Other_____

For the purpose of:

- ☐ Self (at the request of the individual)
- ☐ Continuing care
- ☐ Insurance
- ☐ Other:_____

**External records, or records sent to us by another provider or facility are not our property and we are not legally permitted to disclose these records.*
***If you are requesting the release of x-rays, please be advised that the originals are part of your permanent medical records. They may be released only to another physician or medical facility within the State of Oregon. You may purchase copies for personal use, litigation, or to be sent out of state.*

This Authorization will expire on the earlier of _____(date) or 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described material.

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

The following items must be initialed to be included in the use/disclosure of your health information:

____HIV?AIDS
____Drug/alcohol diagnosis, treatment, or referral information
____Mental health
____ Genetic testing information

<u>*Please note there may be a charge for photocopying your records.***</u>**

Signature: _____ Date: _____

The Orthopedic and Sports Medicine Center of Oregon, LLC

01/2005