DESERT ORTHOPEDICS

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.*

I authorize: _____
(Name of person / entity / facility disclosing information)

_____ _____ _____ _____
(Address of person / entity) (City) (State) (Zip Code)

to use and disclose a ☐ Paper copy **and/or** ☐ Electronic copy of the specific health information described below regarding:

_____
(Name of individual)

Consisting of: __Chart Notes __ Surgery Reports __ Labs __ Billing Information __ Xray/MRI Images on Disk *(Charge May Apply)*

__ Other, specify: _____ Body Part: _____

To: _____
(Name of recipient)

_____ _____ _____ _____
(Address of recipient) (City) (State) (Zip Code)

for the purpose of: *(Describe each purpose of disclosure)* _____ Continued Care _____ Legal _____ Disability
_____ School Entry _____ Other, specify _____

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 information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral 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 will mean you 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. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

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 uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to *Desert Orthopedics, Attn: Medical Records, 1303 NE Cushing Dr., Suite 100, Bend, Oregon 97701* and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure 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 information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____