AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Oregon Anesthesiology Group
Phone (503) 299-9906

Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is required to make the disclosure.

PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Initial:

Nickname/Maiden Name:	Date of Birth:	Telephone Number: Okay to leave a detailed message? Yes □ No □

Complete Mailing Address:

INFORMATION ABOUT THE USE AND DISCLOSURE

I authorize **Oregon Anesthesiology Group** to use and disclose a copy of the specific health information described below consisting of (please initial):

____ Billing Records ____ IPC Clinical Chart Notes
____ Other Specific Documents: _____
_____
_____

Required: Date(s) of service or date range of the records to be released:
_____

If the information to be disclosed contains any of the types of medical records or information listed below, additional laws relating to the use or 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 provided***.

____ HIV/AIDS information
____ Genetic testing information
____ Mental health information
____ Drug/alcohol diagnosis, treatment or referral information

Release my medical records or billing records to:

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax Number: _____

For the purpose of: _____

Redisclosure: I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer 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.

Revocation: You may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If you revoke this authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. To revoke this authorization, please send a written statement to the OAG Privacy Officer, at Oregon Anesthesiology Group, P.C., 707 SW Washington St., Suite 700, Portland, OR 97205 and state that you are revoking this authorization.

Expiration: Unless revoked earlier, this authorization will expire on the earlier of one (1) year from the date of signing or on _____ (provide either a date or event).

SIGNATURE OF PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

I authorize **Oregon Anesthesiology Group** to use and disclose my medical records or billing records, as described above.

Signature: _____ Date: _____
(Patient or Patient's Personal Representative)

Printed Name: _____

If you are signing as a Personal Representative of the patient you must provide a description of your authority to act on behalf of the patient and a copy of official documentation granting this authority:_____
_____

Source Oregon Revised Statute §192.566 Authorization Form