CASCADE INTERNAL MEDICINE SPECIALISTS

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization:

_____, _____
(Patient's name) (Patient's date of birth)

Consisting of _____
(Describe the information to be used/disclosed)

and send the information to:

Dr. _____
Cascade Internal Medicine Specialists
2115 NE Wyatt Court, Suite 101, Bend, OR 97701
Telephone: 541-318-0124 Fax: 541-318-0182

from:_____

for the purpose of: _____
(Describe purpose of disclosure)

_____

If the information to be disclosed contains any of the types of records or information listed below, the laws relating to this information may apply. I understand that this information will be disclosed 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

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

Provider 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 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 necessary to make that disclosure.

You may revoke this authorization 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 authorization form. Any use or disclosure already made with your permission cannot be undone. To revoke please send a written statement to Clinical Manager, Cascade Internal Medicine Specialists@ 2115 NE Wyatt Court, Bend, OR 97701. Verbal revoking of authorization will not be accepted.

I have read this authorization and I understand it._____Date_____
(Signature) parent or representative
Description of personal representative authority: _____

Unless revoked this authorization will expire: _____
(Write date or event)